

<i>SERFF Tracking Number:</i>	<i>INCS-125397225</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan-American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>37914</i>
<i>Company Tracking Number:</i>	<i>PALIC PAL-LP-2007</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Group Term Life AD&D</i>		
<i>Project Name/Number:</i>	<i>PALIC Group Life/</i>		

Filing at a Glance

Company: Pan-American Life Insurance Company

Product Name: Group Term Life AD&D

SERFF Tr Num: INCS-125397225

State: ArkansasLH

TOI: L04G Group Life - Term

SERFF Status: Closed

State Tr Num: 37914

Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Co Tr Num: PALIC PAL-LP-2007

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Author: Renee Weaver

Disposition Date: 04/02/2008

Date Submitted: 01/17/2008

Disposition Status: Approved

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: PALIC Group Life

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/02/2008

State Status Changed: 04/02/2008

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer, Association

Deemer Date:

Submission for: Pan-American Insurance Company

NAIC#: 67539

FEIN#: 72-0281240

RE: Group Life and Accidental Death and Dismemberment Product Filing

SERFF Tracking Number: INCS-125397225 State: Arkansas
Filing Company: Pan-American Life Insurance Company State Tracking Number: 37914
Company Tracking Number: PALIC PAL-LP-2007
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: Group Term Life AD&D
Project Name/Number: PALIC Group Life/

Insurance Company Forms:

Policy: PAL-LP-2007

Certificate: PAL-LC-2007

AD&D Optional Benefit Rider: PAL-LADR-2007

Accelerated Death Benefit Rider: PAL-LADBR-2007

Group Employer Application: PAL-LGA-2007-ER

Group Association Application: PAL-LGA-2007-ASSOC

Employee Application: PAL-LIA-2007-EE

Association Application: PAL-LIA-2007-ASSOC

Innovative Compliance Solutions has been retained by Pan-American Insurance Company to file the above mentioned filing in your state. Please address any future correspondence and/or approvals to my attention.

The enclosed group insurance forms are hereby submitted for your review and approval. These forms are new and do not replace any previously approved forms.

This is a group product that can provide any combination of the following: (1) Basic Term Life Coverage; (2) Basic Accidental Death Coverage; (3) Basic Accidental Death and Dismemberment Insurance; (4) Supplemental Term Life Coverage; (5) Supplemental Accidental Death Coverage; or (6) Supplemental Accidental Death and Dismemberment Coverage. The Policyholder may also elect to provide additional Accidental Death and Dismemberment benefits or an Accelerated Death Benefit. The applicable Policy/Certificate Rider will be customized and issued to the insured. Dependent coverage may be included for Supplemental Term Life Coverage. This product is intended for use with eligible employer and association groups in your state.

To provide flexibility, all variable text is indicated by brackets. The bracketed text shows the most restrictive provision that would be offered to the insured. Generally, any provision in brackets may be included in the certificates issued to employees or members may be removed in accordance with the plan options offered to groups and the election made by the groups applying. Letters and numbers (excluding form numbers) may be varied. Colons, semicolons, semicolons followed by the word "or" and semicolons followed by the words "and/or" may be omitted. If omitted, a period will be substituted, if necessary. Articles such as "a" and "an" may be substituted as grammatically necessary. Variable text will never exclude or limit provisions required by the jurisdiction in which the Group Policy is issued.

SERFF Tracking Number:	INCS-125397225	State:	Arkansas
Filing Company:	Pan-American Life Insurance Company	State Tracking Number:	37914
Company Tracking Number:	PALIC PAL-LP-2007		
TOI:	L04G Group Life - Term	Sub-TOI:	L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name:	Group Term Life AD&D		
Project Name/Number:	PALIC Group Life/		

Please note the following information:

- The forms contained in this filing are to be used on an insert form basis. In lieu of filing modifications via amendments, the insert form(s) impacted by the modification will be submitted for review and approval. Please refer to the "Forms Listing" document for all of the forms to be used in conjunction with this new policy/certificate series.
- The company's state of domicile is Louisiana.
- Sale of the product will be through properly licensed agents and brokers or it may be marketed on a direct issue basis.
- Forms are being submitted in final printed format. Printing is subject to changes in ink, paper stock, page numbers, margins, position and format. Printing standards will never be less than that required by your state. We would like to reserve the option of using the form in its submitted format electronically.

Your review and subsequent approval of this form will be appreciated. Should you have any questions, or need additional information, please contact me by email at rweaver@innovative-compliance.com or by telephone at 763-323-8643. My fax number is 763-712-8001.

Sincerely,
Renee Weaver
Compliance Consultant

Company and Contact

Filing Contact Information

(This filing was made by a third party - innovativecompliancesolutions)

Renee Weaver, Consultant	rweaver@innovative-compliance.com
PO Box 773	(763) 323-8643 [Phone]
Anoka, MN 55303	(763) 712-8001[FAX]

Filing Company Information

Pan-American Life Insurance Company	CoCode: 67539	State of Domicile: Louisiana
601 Poydras St	Group Code:	Company Type:

SERFF Tracking Number: *INCS-125397225* *State:* *Arkansas*
Filing Company: *Pan-American Life Insurance Company* *State Tracking Number:* *37914*
Company Tracking Number: *PALIC PAL-LP-2007*
TOI: *L04G Group Life - Term* *Sub-TOI:* *L04G.103 Renewable - Single Life -*
Fixed/Indeterminate Premium

Product Name: *Group Term Life AD&D*
Project Name/Number: *PALIC Group Life/*

New Orleans, LA 70130
(877) 569-3075 ext. [Phone]

Group Name:
FEIN Number: 72-0281240

State ID Number:

SERFF Tracking Number:	INCS-125397225	State:	Arkansas
Filing Company:	Pan-American Life Insurance Company	State Tracking Number:	37914
Company Tracking Number:	PALIC PAL-LP-2007		
TOI:	L04G Group Life - Term	Sub-TOI:	L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name:	Group Term Life AD&D		
Project Name/Number:	PALIC Group Life/		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	Yes
Fee Explanation:	\$100 per filing
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pan-American Life Insurance Company	\$0.00	01/17/2008	

SERFF Tracking Number:	INCS-125397225	State:	Arkansas
Filing Company:	Pan-American Life Insurance Company	State Tracking Number:	37914
Company Tracking Number:	PALIC PAL-LP-2007		
TOI:	L04G Group Life - Term	Sub-TOI:	L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name:	Group Term Life AD&D		
Project Name/Number:	PALIC Group Life/		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	04/02/2008	04/02/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fee	Note To Reviewer	Renee Weaver	03/24/2008	03/24/2008
Filing Fee	Note To Filer	Linda Bird	03/19/2008	03/19/2008

<i>SERFF Tracking Number:</i>	<i>INCS-125397225</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan-American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>37914</i>
<i>Company Tracking Number:</i>	<i>PALIC PAL-LP-2007</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Group Term Life AD&D</i>		
<i>Project Name/Number:</i>	<i>PALIC Group Life/</i>		

Disposition

Disposition Date: 04/02/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: INCS-125397225 State: Arkansas

Filing Company: Pan-American Life Insurance Company State Tracking Number: 37914

Company Tracking Number: PALIC PAL-LP-2007

TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: Group Term Life AD&D

Project Name/Number: PALIC Group Life/

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Letter of Authorization		Yes
Supporting Document	Readability Certification		Yes
Supporting Document	Accelerated Death Benefit Actuarial Memo		No
Supporting Document	Forms List		Yes
Form	Group Policy		Yes
Form	Certificate		Yes
Form	AD&D Policy/Certificate Rider		Yes
Form	Acc Death Policy/Certificate Rider		Yes
Form	Group Employer Application		Yes
Form	Group Association Application		Yes
Form	Employee Application		Yes
Form	Association Application		Yes

<i>SERFF Tracking Number:</i>	<i>INCS-125397225</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan-American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>37914</i>
<i>Company Tracking Number:</i>	<i>PALIC PAL-LP-2007</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Group Term Life AD&D</i>		
<i>Project Name/Number:</i>	<i>PALIC Group Life/</i>		

Note To Reviewer

Created By:

Renee Weaver on 03/24/2008 06:35 PM

Subject:

Filing Fee

Comments:

I apologize. The filing fee has been mailed. Check number 9150 for \$100.

Thank you.

SERFF Tracking Number: *INCS-125397225* *State:* *Arkansas*
Filing Company: *Pan-American Life Insurance Company* *State Tracking Number:* *37914*
Company Tracking Number: *PALIC PAL-LP-2007*
TOI: *L04G Group Life - Term* *Sub-TOI:* *L04G.103 Renewable - Single Life -*
Fixed/Indeterminate Premium

Product Name: *Group Term Life AD&D*
Project Name/Number: *PALIC Group Life/*

Note To Filer

Created By:

Linda Bird on 03/19/2008 08:29 AM

Subject:

Filing Fee

Comments:

Please be advised the Department has not received your check on the filing submitted on 1/17/2008. We will hold you filing in a pending status until the fee is received.

SERFF Tracking Number: INCS-125397225 State: Arkansas

Filing Company: Pan-American Life Insurance Company State Tracking Number: 37914

Company Tracking Number: PALIC PAL-LP-2007

TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: Group Term Life AD&D

Project Name/Number: PALIC Group Life/

Form Schedule

Lead Form Number: PAL-LP-2007

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	PAL-LP-2007	Policy/Cont	Group Policy	Initial		53	AR PAL-LP-2007 Policy FINAL 1-08.pdf
	PAL-LC-2007	Certificate	Certificate	Initial		53	AR PAL-LC-2007 Certificate FINAL 1-08.pdf
	PAL-LADR-2007	Certificate	AD&D Amendmen t, Insert Page, Endorseme nt or Rider	Initial		53	PAL-LADR-2007 Optional AD Rider 12-5-07.pdf
	PAL-LADBR-2007	Certificate	Acc Death Amendmen t, Insert Page, Endorseme nt or Rider	Initial		53	PAL-LADBR-2007 Accel Death Rider 12-5-07.pdf
	PAL-LGA-2007-ER	Application/ Enrollment	Group Employer Application Form	Initial		0	PAL-LGA-2007-ER Employer App.pdf
	PAL-LGA-2007-ASSOC	Application/ Enrollment	Group Association Application Form	Initial		0	PAL-LGA-2007-ASSOC Group Association App.pdf
	PAL-LIA-	Application/	Employee	Initial		0	PAL-LIA-

<i>SERFF Tracking Number:</i>	<i>INCS-125397225</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan-American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>37914</i>
<i>Company Tracking Number:</i>	<i>PALIC PAL-LP-2007</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Group Term Life AD&D</i>		
<i>Project Name/Number:</i>	<i>PALIC Group Life/</i>		
2007-EE	Enrollment Application Form		2007-EE employee app.pdf
PAL-LIA- 2007- ASSOC	Application/ Association Enrollment Application Form	Initial	0 PAL-LIA- 2007-ASSOC app.pdf

PAN-AMERICAN LIFE INSURANCE COMPANY

PAN-AMERICAN LIFE CENTER

[601 POYDRAS

New Orleans, Louisiana 70130

TOLL FREE: 1-877-569-3075]

**[GROUP TERM LIFE INSURANCE [AND
24-HOUR ACCIDENTAL DEATH [AND DISMEMBERMENT]] INSURANCE]**

**[SUPPLEMENTAL GROUP TERM LIFE [AND
24-HOUR ACCIDENTAL DEATH [AND DISMEMBERMENT]] INSURANCE]**

Policyholder: [ABC Group]

Group Policy Number:[G-123456]

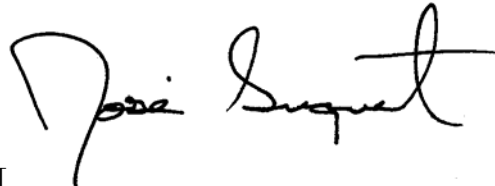
Policy Effective Date: [June 1, 2008]

Governing Jurisdiction: This Policy is delivered in [State] and is subject to the laws of that jurisdiction.

Premium Due Dates: Premiums are due on the Policy effective date and on the first of each month thereafter.

Policy Anniversary: [June 1st of each year beginning in 2008].

PAN-AMERICAN LIFE INSURANCE COMPANY



[
[President and Chief Executive Officer]

[Participating or Non-Participating Policy]

Policyholder Service Office of Company: Pan-American Life Insurance Company

Address: 601 Poydras Street, New Orleans, LA 70130

Telephone: 1-77-9394550

If we at Pan-American Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department - Consumer Services Division

1200 West Third Street

Little Rock, Arkansas 72201-1904

Telephone: (501) 371-2600

TABLE OF CONTENTS

TITLE	PAGE
Schedule of Insurance.....	[X]
Monthly Premium Rates.....	[X]
Definitions	[X]
Eligibility Provisions	[X]
[Dependent Provisions]	[X]
Life Insurance Provisions	[X]
Conversion Privilege	[X]
Waiver of Premium Provisions	[X]
[24-Hour Accidental Death [and Dismemberment] Insurance Provisions]	[X]
Claim Provisions.....	[X]
Beneficiary and Settlement Provisions	[X]
Premium Provisions	[X]
General Provisions.....	[X]

SCHEDULE OF INSURANCE

[Policy Number: [G-123456]
Policyholder Name: [ABC Group]
Effective Date: [June 1, 2008]
Policy Anniversary Date: [June 1]]

ELIGIBLE CLASS

[All Active Full-Time Employees of the Policyholder working a minimum of thirty (30) hours per week, this does not include seasonal or temporary employees].

[All eligible Subscribers of the Policyholder.]

[Associated Companies of the Policyholder.
Effective Date: September 1, 2008]

[SERVICE WAITING PERIOD

[Employees hired before 06-01-08 are eligible for coverage on the Policy effective date].

[Employees hired on or after 06-01-08 will be eligible for coverage on the premium due date following [ninety (90) days] of continuous active employment].]

BASIC INSURANCE

Class Description	[Life Amount]	Non-Contributory
		[Accidental Death [and Dismemberment] Principal Sum [\$10,000.00]]
[All Eligible Classes]	[\$10,000.00]	

Amount of insurance reduces to 65% at age 65, to 40% of the original amount at age 70, to 25% of the original amount at age 75; benefit terminates at retirement.

[SUPPLEMENTAL TERM LIFE INSURANCE]

Class Description	Contributory Supplemental Life Amount
[All Eligible Classes]	[Increments \$1,000 units up to \$100,000]
[All Eligible Classes with Subscribers:	
[Under 65:]	[Increments of \$1,000 units up to \$25,000]
[65 and older:]	[Increments of \$1,000 units up to \$10,000]
[All Eligible Classes with Subscribers between the ages of [18] and [64] subject to evidence of insurability]	[Increments \$1,000 units up to \$100,000]

[SUPPLEMENTAL ACCIDENTAL DEATH [AND DISMEMBERMENT] INSURANCE]

Class Description	Contributory Supplemental Accidental Death [and Dismemberment] Amount
[All Eligible Classes]	[Increments \$1,000 units up to \$100,000]
[All Eligible Classes with Subscribers:	
[Under 65:]	[Increments of \$1,000 units up to \$25,000]
[65 and older:]	[Increments of \$1,000 units up to \$10,000]
[All Eligible Classes with Subscribers between the ages of [18] and [64] subject to evidence of insurability]	[Increments \$1,000 units up to \$100,000]

1

DEPENDENT LIFE INSURANCE

<u>Class</u>	<u>Benefit Amount</u>
Spouse	[\$2,000.00]
Child(ren)	
14 days to 6 months	[\$1,000.00]
6 months to age [19]	[\$1,000.00]
(to age [25] if a Full-Time student)	

1

MONTHLY PREMIUM RATES

The initial monthly premium rates as of the Policy Effective Date for the coverages provided by this Policy are as on file with The Company and the Policyholder.

DEFINITIONS

[ACTIVE WORK and ACTIVELY AT WORK means an Employee is Actively At Work with the Policyholder on the day insurance becomes effective, which is one of the Policyholder's scheduled work days if:

1. the Employee is performing his or her regular occupation at the Policyholder's usual places of business or at some location to which the Policyholder's business requires the Employee to travel; or
2. the day is a scheduled holiday, vacation day or period of Policyholder approved paid leave of absence.

An Employee is considered Actively At Work on a day, which is not one of the Policyholder's scheduled workdays only if the Employee was actively at work on the last preceding scheduled work day.

A person other than an Employee is considered Actively At Work if able to perform all activities another person of the same age and sex could normally perform and is not:

1. a patient in a hospital or hospice, or receiving outpatient care for chemotherapy or radiation therapy;
2. confined at home under the care of a Physician for sickness or injury;
3. unable to perform any of the activities of daily living expected of a person of the same age; e.g., mobility, transferring, feeding; without human supervision or assistance; or
4. receiving disability benefits from any source due to Sickness or Injury.]

AFFILIATE or SUBSIDIARY means a company, corporation, partnership, or person named as such in the Policyholder's application for coverage under the Policy. Such firms must be under the control of the Policyholder through ownership, contract or other arrangement. Any records of such firm which have a bearing on the insurance provided in the Policy will be deemed to be records of the Policyholder. If an Affiliated or Subsidiary firm ceases to be under the control of the Policyholder, the insurance of the Insured persons of such firm will automatically cease on the date of such change, whether or not the change is reported to Us.

The inclusion of the Policyholder's Affiliated or Subsidiary firm will have no effect on the Policyholder's rights under this Policy.

[APPLIES ONLY TO EMPLOYER SUPPLEMENTAL GROUP TERM LIFE INSURANCE.

ANNUAL ENROLLMENT PERIOD means the period in each calendar year when an eligible Subscriber may change benefit elections under the policy. Both the Policyholder and The Company must agree upon this period.]

[CONTRIBUTORY means the Subscriber pays either all or part of the cost of the insurance.]

DISABLED OR DISABILITY refers to any Disability which results from a Sickness or Injury that prevents the Subscriber from engaging in any gainful business or occupation for which the Subscriber is or could become reasonably qualified by reason of education, training, or experience. The Subscriber must be under the regular care and treatment of a Physician other than themselves.

[DOMESTIC PARTNER means a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Subscriber has established a Domestic Partnership. In no event, will a person's legal spouse be considered a Domestic Partner.]

[DOMESTIC PARTNERSHIP means a relationship between the Subscriber and one other person of the [opposite sex] [same sex] [opposite or same sex]. The following requirements apply to both persons:

1. [They share the same permanent residence and the common necessities of life;
2. They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
3. Each is at least 18 years of age;
4. Each is mentally competent to consent to contract;
5. Neither is currently married to, or Domestic Partner of, another person under either a statutory or common law;
6. They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:

- a. have a single dedicated relationship of at least 6 months duration;
 - b. joint ownership of residence;
 - c. at least two of the following:
 - i. joint ownership of an automobile;
 - ii. joint checking, bank or investment account;
 - iii. joint credit account;
 - iv. lease for a residence identifying both partners as tenants;
 - v. a will and/or life insurance policies which designates the other as primary beneficiary.
7. The Subscriber and Domestic Partner must jointly sign an affidavit of Domestic Partnership.]

ELIGIBLE PERSON means an employee of the Policyholder or other person whose connection with the Policyholder meets the eligibility requirements specified in both the application and the Policy.

[**EMPLOYEE** means any person who works for the Policyholder at the Policyholder's place of business and whose income is reported for tax purposes using a W-2 form.]

EVIDENCE OF INSURABILITY means an Eligible Person will satisfy the insurability requirement on the day The Company agrees in writing to accept the person as insured for that amount. To determine a person's acceptability for coverage, The Company will require evidence of good health and may require it to be provided at the Insured Person's expense.

[**FULL-TIME EMPLOYEE** means any person who is regularly scheduled to work for the Employer for at least thirty (30) hours per week, at the Employer's usual place or places of business.]

INJURY means accidental loss or bodily harm, which results directly and independently of all other causes from the accident. All injuries that are suffered in one accident are considered to be one injury.

INSURED PERSON means the Subscriber [or an enrolled Dependent,] who is eligible for coverage under the Policy for whom insurance is elected, the required premium is paid, and coverage is in force under the Policy.

[APPLIES ONLY TO SUPPLEMENTAL GROUP TERM LIFE INSURANCE]

LIFE STATUS CHANGE a Life Status Change is an event qualifying a Subscriber to make changes in benefit selections at a time other than an Annual Enrollment Period. The following events are Life Status Changes.

1. Marriage
2. Divorce, annulment or legal separation
3. Birth or adoption of a child
4. Death of a spouse
5. Termination of a spouse's employment
6. A change in the benefit plan available to the Subscriber's Spouse
7. [A change in the employment status of the Employee or the Employee's Spouse that affects either person's eligibility for benefits].]

[**NON-CONTRIBUTORY** means the Subscriber does not pay any part of the cost of the insurance.]

PHYSICIAN means a licensed Doctor of Medicine (MD) or Osteopathy (DO). The term does not include the Subscriber, Subscriber's spouse, or the immediate family of the Subscriber (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in the Subscriber's household.

POLICYHOLDER means the entity or other organization to whom this Policy is issued.

[**SERVICE WAITING PERIOD** means the period of time that begins with the Employee's most recent date of employment and ends on the day prior to the day the Employee is eligible for coverage under the Policy.]

SICKNESS means physical or mental illness or disease.

SUBSCRIBER means an Eligible Person who is properly enrolled for coverage under the Policy. The Subscriber is the person [(who is not a Dependent)] on whose behalf the Policy is issued to the Policyholder.

WE/US/OUR/THE COMPANY means Pan-American Life Insurance Company.

ELIGIBILITY PROVISIONS

ELIGIBLE CLASSES

WHEN A SUBSCRIBER BECOMES ELIGIBLE

A person becomes eligible for the coverage provided by the Policy on [the later of the following:

1. [The Policy's Effective Date]; or
2. The date the person completes the Service Waiting Period.]

EFFECTIVE DATE

Insurance becomes effective on the latest of the following:

1. The first day of the month following the date that the person becomes eligible for the coverage;
2. [The date the person resumes Active Work, if not Actively At Work on the day such person became eligible;]
3. The date the person's evidence of insurability is approved by The Company, if required.

EVIDENCE OF INSURABILITY

The Company requires satisfactory evidence of insurability when:

1. The Company's underwriting guidelines requires it;
2. The person makes written application for insurance more than 31 days after becoming eligible for coverage;
3. The person makes written application for insurance after requesting to cancel insurance[; or
4. The person makes written application to increase Supplemental Group Term Life Insurance [by more than 1 level(s) of coverage].]

CHANGES IN AMOUNT OF INSURANCE

Any increases in the amount of a Subscriber's insurance will take effect on the first day of the month coinciding with or following the date of increase.

Decreases in the amount of a Subscriber's insurance will take effect on the first day of the month following the date of change.

[Applies only to employer Supplemental Group Insurance]

During an Annual Enrollment Period, or within 31 days after a Life Status Change, a Subscriber currently insured for Supplemental Group [Term Life] Insurance may increase his or her Supplemental Group [Term Life] Insurance benefits [by one (1) level] without submitting evidence of insurability.]

TERMINATION OF INSURANCE

A Subscriber's coverage will end on the earliest of the following dates:

1. The date the Subscriber is no longer eligible;
2. The date such Subscriber enters the armed services for any state or country on active duty; except for duty of thirty (30) days or less for training in the Reserves or National Guard;
3. The date the Policy terminates;
4. The day after the end of the period for which premiums are paid;
5. The last day of the month in which the Subscriber requests termination;
6. [The last day of the Policy month following the date the Subscriber ceases to be Actively At Work, except if the Subscriber ceases Active Work as a result of:
 - a. A temporary layoff or leave of absence. The life insurance may be continued until the Policyholder stops paying premium for the Subscriber or otherwise cancels the insurance. Such insurance will not continue for more than three (3) months past the Subscriber's last day of Active Work. Upon written request from the Policyholder, We may agree in writing to continue the Subscriber's insurance for an additional number of months during lay-off or leave of absence.
 - b. Injury or Sickness. The life insurance may be continued while the Subscriber remains totally Disabled as a result of the Injury or Sickness. Such insurance will not continue past the earlier of:
 - i. six (6) months from the date the Subscriber was no longer Actively At Work unless the Policyholder obtains the consent of The Company in writing for a longer period; or

- ii. the date the Policyholder stops paying premium for the Subscriber or otherwise cancels the insurance. The Subscriber may pay the premium to the Policyholder during this period in order to continue coverage during Injury or Sickness.
- c. Labor dispute. The basic life insurance will be continued for those Insured Persons who elect to pay the premium to the Policyholder. Such insurance will not continue for more than six (6) months past the Subscriber's last day of Active Work.]

[FAMILY CARE LEAVE

If the Employer is subject to the Family & Medical Leave Act of 1993 and the Subscriber's approved leave of absence is for family care pursuant to the Act, payment of premium for the Subscriber shall keep coverage in effect for the duration(s) prescribed by the Act. The Employer is solely responsible for notifying the Subscriber of the availability and duration of family leaves.]

DEPENDENT PROVISIONS

ELIGIBILITY

Each Subscriber becomes eligible for Dependent's insurance on the later of:

1. the date the Subscriber becomes insured; or
2. the effective date of Dependent Insurance; or
3. the date the Subscriber first acquires a Dependent.

ELIGIBLE DEPENDENTS

A Subscriber's Dependents include:

1. A spouse who is not legally separated or divorced and is less than age [70]. [All references to the spouse of a Subscriber shall include a Domestic Partner.]
2. An unmarried natural or legally adopted child:
 - a. from [14 days] to [19] years; or
 - b. [19] years but less than [25] years old and enrolled as a full-time student in an accredited college or university.
 - c. who is [19] or more years of age, primarily supported by the Subscriber, incapable of self-support by reason of mental or physical handicap. Proof of the condition and dependent must be submitted to Us within 31 days after the child ceases to qualify as a Dependent. We may, during the next two (2) years, from time to time, require proof of the continued condition and dependence. Thereafter, We may require proof no more than once a year.

The term "child" means a child born to or legally adopted by the Subscriber; a child for whom the Subscriber is the legal guardian; or a child placed with the Subscriber for the purpose of adoption. It also means a stepchild, foster child, or other child who depends upon the Subscriber for support and lives with the Subscriber in a regular parent/child relationship.

A Dependent does not include:

1. anyone enrolled under the Policy as a Subscriber; or
2. anyone serving in the Armed Forces for any state or county, except for duty of thirty (30) days or less for training in the Reserves or National Guard.

EFFECTIVE DATE

The Subscriber's Dependent insurance for each Dependent will become effective on the latest of:

1. the date the Subscriber becomes eligible for Dependent insurance;
2. the date The Company approves any required evidence of insurability on each Dependent of the Subscriber;
3. the date following the date an eligible Dependent, other than a newborn child, is discharged from house confinement, or hospital or other health care facility and resumes the normal activities of someone of like age and sex;
4. the date a Dependent child placed with the Subscriber for adoption while this coverage is in force. Such coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

TERMINATION OF DEPENDENT'S INSURANCE

The Dependent insurance of a Dependent will cease on the earliest of the following dates:

1. 31 days after the end of the period for which premiums have been paid;
2. the date Dependent insurance terminates;
3. the date the Subscriber's insurance under the Policy terminates;
4. the date the Dependent ceases to be a Dependent as defined in this Policy; or
5. the date the coverage under the Policy is canceled.

LIFE INSURANCE PROVISION

DEATH BENEFITS

We will pay the Insured Person's beneficiary the amount of insurance in force on the date of death when We receive satisfactory proof of the Insured Person's death. The benefit will be paid in accordance with the Beneficiary Provision.

SETTLEMENT OPTIONS

Instead of a single lump sum payment, the Insured Person may choose to have all or part of the insurance paid under one of the settlement options We have available. [We will give the Insured Person full information about the options upon request.]

SUICIDE LIMITATIONS

If an Insured Person's death occurs by suicide, while sane or insane, within 2 years of the Insured Person's Effective Date the only benefit payable will be a refund of the premiums which have been paid for the Insured Person.

CONVERSION PRIVILEGE

An individual life policy, known as a conversion policy, may be purchased through The Company without evidence of insurability if all or part of a Subscriber's life insurance terminates for any reason except non-payment of premium.

Application and payment of the first premium must be made to The Company within 31 days after coverage under the Policy ends.

Any policy issued will be for an amount not to exceed the amount of life insurance which was terminated. It may be on any form provided by The Company, except term, without disability or other supplemental benefits. Premium for the conversion insurance will be based on the Subscriber's age and class of risk, and the type and amount of coverage issued. The policy will not cover Dependents.

CONVERSION UPON TERMINATION OR AMENDMENT OF POLICY

If this Policy terminates or is amended to terminate any class of Subscribers, or the Policyholder cancels participation under the Policy, coverage cannot be converted unless the individual has been insured under the Policy for at least five (5) years. The amount of conversion insurance will be the lesser of the amount of life insurance in force under the Policy, or \$10,000.

INSURANCE CONTINUED UNDER GROUP POLICY

If the Subscriber has converted to an individual Policy and again becomes insured under this Group Life Policy, the individual Policy must be returned to Us before the Subscriber may be insured under this Policy.

DEATH DURING CONVERSION PERIOD

If a Subscriber dies within the thirty-one (31) day conversion period, We will pay the death benefit whether or not the Subscriber applied for conversion insurance. If the first premium was paid for the conversion policy, the amount of premium paid will be refunded and the conversion will be void.

WAIVER OF PREMIUM PROVISIONS

BENEFIT

If a Subscriber becomes totally Disabled while insured under the Policy and is under age 60, We will continue life insurance without payment of premium.

We must receive proof that the Subscriber:

- 1 has been continuously Disabled for [six, nine, or twelve] months; and
- 2 was continuously insured for at least [twelve (12) months] under this Policy prior to becoming Disabled.

Notice of satisfactory proof of Disability must be submitted no later than three (3) months after the Subscriber has been continuously Disabled for [six, nine, or twelve] months. Premiums will be waived from the date The Company agrees in writing to waive premiums. The Company will refund up to twelve (12) months of premiums that were paid after the date the Subscriber became totally Disabled.

CONTINUATION OF WAIVER OF PREMIUM

The Waiver of Premium benefit will be extended for succeeding periods of one (1) year if the Subscriber submits satisfactory proof to Us that Disability continue during the three (3) months before the end of the one (1) year period.

During the two (2) years following the initial proof of total Disability, We may require at reasonable intervals and at Our own expense, a physical examination that the Disability continues. Thereafter, proof will not be required more often than once a year.

If a Subscriber dies during this period, We will pay the benefit in effect on the day the Subscriber became Disabled, subject to the provisions of the Policy that may reduce or terminate coverage on account of age, retirement, acceleration or a change in eligible class.

TERMINATION OF WAIVER OF PREMIUM

Insurance will end for any Subscriber whose premiums are waived on the earliest of the following dates:

1. The date the Subscriber is no longer Disabled;
2. The date the Subscriber refuses to submit to any examination required by the Company;
3. The date the Subscriber fails to submit satisfactory proof of continued Disability;
4. The date the Subscriber attains age sixty-five (65);
5. The date the Subscriber retires[;
6. The date the Subscriber accepts employment or is found able to accept employment for which the Subscriber is reasonable fitted by training, education or experience].

Insurance will not be affected by termination or amendment of the Policy after the Subscriber becomes totally Disabled.

[CONTINUATION OF DEPENDENT LIFE INSURANCE

We will continue the Subscriber's Dependent Life insurance without payment of premium provided:

1. the Dependent insurance was in force prior to the Subscriber becoming Disabled; and
2. the Subscriber continues to satisfy the terms of this provision.

Dependent Insurance will end for any Subscriber whose premiums are waived when the first of the following occurs:

1. the Subscriber's premiums are no longer being waived;
2. the Subscriber fails to meet the terms of this Policy;
3. the Subscriber is no longer Disabled;
4. the Dependent insurance provided under this Policy is terminated; or
5. the Subscriber dies.

]

PORTABILITY

Portability is the Subscriber's right to continue insurance at the time insurance ends. [It does not apply to Basic Life Insurance Benefit [or the Accidental Death [and Dismemberment] Benefit].] Coverage continued under this provision is subject to all other provisions and limitations of the Policy.

ELIGIBILITY

A Subscriber may continue insurance if coverage ends for any reason other than termination of the Policy, is under age [70], and has been continuously covered under the Policy for at least [12] months prior to the date insurance terminates. Insurance may not be continued if the Subscriber's coverage terminates due to disability or retirement.

AMOUNT OF INSURANCE

The Subscriber may continue insurance up to the amount terminated under the Policy. Waiver of Premium [and Accelerated Death Benefits are] not available. The Subscriber must submit an application to The Company and pay the required premium. The Subscriber may not elect to port coverage at a later date, if the Subscriber does not elect to continue insurance within 31 days after coverage ends

PREMIUM

The premium for this coverage will be based on the rate in force for the Policy. The required premium will be at the rates that are on file with The Company and the Policyholder.

LIMITATIONS AND TERMINATION

Coverage continued is subject to the following conditions:

1. Coverage will terminate when The Company cancels coverage for all members of the Subscriber's class;
2. Coverage will terminate the date after the end of the period for which premiums are paid;
3. Insurance terminates at age [70];
4. Coverage will terminate when the Policy terminates;
5. Conversion Privilege will apply if coverage ends due to reaching the termination age;
6. If coverage lapses due to nonpayment of premium, Conversion Privilege will not apply.

24-HOUR ACCIDENTAL DEATH [AND DISMEMBERMENT] INSURANCE

If, within [ninety (90)] days from the date of an accident covered by this Policy, bodily Injuries result in any of the following losses, We will pay the benefits shown opposite such loss.

[Only one amount will be paid if the Subscriber sustains more than one loss as the result of any one accident. We will pay only the largest benefit amount to which the Subscriber is entitled.] This amount will not exceed the Principal Sum shown in the Schedule.

Payment will be made to the Subscriber, or in the event of Subscriber's death, to the named Beneficiary.

Loss of Life	Principal Sum
[Loss of Both Hands or Both Feet	Principal Sum
Loss of Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Sight of One Eye	Principal Sum
Loss of One Foot and Sight of One Eye	Principal Sum
Loss of One Hand	One-half Principal Sum
Loss of One Foot	One-half Principal Sum
Loss of Sight of One Eye	One-half Principal Sum]

[Loss of foot or hand means complete severance through or above the ankle or wrist joint. Loss of an eye means total and irrecoverable loss of sight. Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joints (the joins between the fingers and the hand).]

EXCLUSIONS AND LIMITATIONS

We will not pay for any loss to a Subscriber which results directly or indirectly, wholly or partly from:

1. [Suicide or attempted suicide, while sane or insane;]
2. [Self-destruction while sane or insane within two years from the date of issue of the Policy.]
3. [Intentionally self inflicted injury, while sane or insane;]
4. [Commission of a felony;]
5. [War or any act of war, whether declared or undeclared, terrorism, insurrection, rebellion, or participation in a riot or civil commotion;]
6. [Travel or flight in any vehicle for aerial navigation, including boarding or alighting therefrom;
 - a. while being used for any test or experimental purpose; or
 - b. while the Subscriber is operating, learning to operate or serving as a member of the crew thereof.]
7. [Sickness, disease or bodily infirmity. (This does not include bacterial infection, which results from an accidental cut or wound or accidental ingestion of a poisonous food substance.)]
8. [Taking a poison, or asphyxiation from or inhaling of gas, or intentionally taking narcotics, drugs, barbiturates, hallucinogenic drugs, alcohol or any combination of these when not part of a professional medical treatment.]
9. [Bodily injuries received while the Subscriber was operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit;]
10. [Accident occurring while the Subscriber is serving on full-time active duty in any Armed Forces or in any ambulance, medical, hospital, or civilian noncombatant unit service with such forces, either while serving with or within six months after termination of service in such forces or units; (any premium paid will be returned by Us pro-rata for any period of active-full time duty);]
11. [An injury caused by, or due to, prolonged exposure to dangerous substances, cumulative trauma, or repetitive motion;]
12. [Within two years from the date of issue of the Policy as a result of a specified hazardous occupation or occupations or while the Subscriber is residing in a specified foreign country or countries;]
13. [engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping or using off-road vehicles;]

CLAIM PROVISIONS

NOTICE OF CLAIM

Written notice of claim must be given to The Company within 31 days after a covered loss occurs or begins. If this notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible. The notice must be sent to The Company at its Home Office and should include the Subscriber's name, address, city, state, zip, and policy number.

CLAIM FORMS

The Company will send the claim forms to the Subscriber upon receipt of notice of claim. If the Subscriber does not receive these forms within 15 days, the proof of loss requirement may be met by giving The Company a written statement of the nature and extent of the loss within the time limit stated below.

PROOF OF LOSS

The Company requires written proof of loss within ninety (90) days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one (1) year from such time unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIM

Any benefits payable will be paid when The Company receives proper written proof of loss.

PHYSICAL EXAMINATION AND AUTOPSY

We, at Our own expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. We will also have the right to have any autopsy performed unless prohibited by law.

BENEFICIARY AND FACILITY OF PAYMENT PROVISIONS

Upon receipt of satisfactory proof of the Covered Person's death, The Company will pay the benefits, to the Beneficiary, if any, on file. If there is no designated or specified beneficiary, insurance will be payable to the Covered Person's estate or to one or more of the following surviving relatives:

1. Wife, husband;
2. Child, children;
3. Mother, father;
4. Brothers, sisters.

If the Covered Person's designated beneficiary dies:

1. within [15 days] of the Covered Person's death; and
 2. before The Company receives satisfactory proof of the Covered Person's death,
- payment will be made as if the Covered Person had survived such beneficiary unless provisions have been made. The right of a beneficiary to receive any such amount is subject to the Facility of Payment provision.

BENEFICIARY DESIGNATION

Each beneficiary will be as shown on the Subscriber's application, unless changed. If there is more than one beneficiary named, they will share equally unless otherwise specified in writing.

CHANGING THE BENEFICIARY

A Subscriber may change a Beneficiary at any time by giving written notice to The Company. The beneficiary's consent is not required for this or any other change the Subscriber may make unless the beneficiary designation is irrevocable. Once received by The Company, the change will take effect as of the date on the request. If the Subscriber dies before the request is received The Company will not be liable for any payment that was made before receipt of the request.

FACILITY OF PAYMENT

If any benefit under the Policy becomes payable to:

1. A Covered Person's estate;
 2. A minor, or
 3. Any person who, in the opinion of The Company, is not competent to give a valid release;
- then The Company, at its option, may make payment to any one or more the following:
- a. A person who has assumed the care and support of the Covered Person or beneficiary;
 - b. A person who has incurred funeral or other expenses as a result of the Covered Person's last illness or death;
 - c. The personal representative of the Covered Person's estate;
 - d. Any person related to the Covered Person by blood or marriage.

No payments made to anyone named above may exceed \$250, or the maximum allowed by state law. Any payment made in good faith under this section will fully discharge The Company to the extent of the payment.

PREMIUM PROVISIONS

PREMIUM PAYMENT

Premiums are payable at the Home Office of The Company on or before each premium due date.

PREMIUM DUE DATE

The first premium will be due on the Policy effective date and on the same day of each subsequent month unless the Policyholder and The Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period.

CHANGES IN PREMIUM RATES

The monthly premium rates may be changed by Us from time to time if We give the Policyholder at least thirty-one (31) days advance written notice. No such change will be made until twelve (12) months after the Policy effective date except when the Policyholder requests it.

INCORRECT PREMIUM PAYMENT

Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has ceased, will be refunded without interest when requested by the Policyholder. These premiums will not be refunded for any period before the last anniversary date.

GRACE PERIOD

If, before any premium due date except the first, the Policyholder has not given written notice to The Company that the Policy is to be terminated, a Grace Period of thirty-one (31) days will be given in which to pay the premium then due. The Policy will stay in effect during that time. If any premium is not paid by the end of the Grace Period, the Policy will automatically terminate at the end of the Grace Period; except that if the Policyholder has given written notice in advance of an earlier date of termination, the Policy will terminate as of the earlier date.

NOTICE OF CANCELLATION

The Policyholder or The Company may cancel the Policy as of any Premium Due Date by giving 31 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period.

AVERAGE PREMIUM RATE

As of the date of issue, We will compute an average premium rate per \$1,000.00 of insurance. This rate will be determined by applying the individual rates to the amounts of insurance in force at the respective ages and nearest birthday of all Subscribers, and dividing the aggregate by the total amount of insurance with adjustments for any applicable discounts or loadings. On any Policy anniversary or on any day on which the Policy is amended, either the Policyholder or The Company may require that the average premium rate be recomputed prospectively according to the then attained ages of the insured Subscriber and the table of individual rates then in force (excluding those amounts continued by virtue of the Death During Conversion Period and the Waiver of Premium Provision).

AMOUNT OF PREMIUMS

Each premium shall be equal to the product of the total amount of insurance (excluding those amounts continued by virtue of the Death During Conversion Period and the Waiver of Premium Provisions) in force on the due date, and the average premium rate then in effect. However, any other method may be used which produces approximately the same total amount and which is mutually agreeable to the employer and Us.

GENERAL PROVISIONS

EXECUTION OF POLICY

The Policy is executed at the Home Office of Pan-American Life Insurance Company in New Orleans, Louisiana.

CONSIDERATION

The Policy is issued to the Policyholder in consideration of the application and payment of premiums.

INSURANCE DATA

The Policyholder will give The Company all of the data that it needs to administer the Policy. We have the right to examine the Policyholder's records relative to these benefits at any time while the Policy is in force. It also has the right until all rights and obligations under the Policy are finally determined.

ADMINISTRATION

We will deal solely with the Policyholder who will be deemed to be acting as an agent for each Subscriber. Any action taken by the Policyholder will be binding on the Subscriber.

INCONTESTABILITY

We will not contest the Policy after two (2) years from the date of onset of issue except for failure to pay premium. No statement made by an Eligible Person will be used to deny a claim after the person's coverage has been in force for a period of two (2) years during the Eligible Person's life; then only if the statement is made in writing and signed by the Eligible Person.

STATEMENT NOT WARRANTIES

All statements made by the Policyholder or by an Eligible Person will, be deemed representations and not warranties. No statement made by the Policyholder or by the Eligible Person to obtain insurance will be used to avoid or reduce the insurance unless:

1. It is made in writing;
2. It is signed by the Policyholder or the Eligible Person; and
3. A copy is sent to the Policyholder, the Eligible Person or the Eligible Person's Beneficiary.

ENTIRE CONTRACT

The entire contract will be made up of the Policy, Certificates, the application of the Policyholder, any individual Subscriber applications, Amendments and Riders will constitute the entire Policy between parties.

POLICY CHANGES

Changes may be made in the Policy only by amendment signed by the Policyholder and by The Company acting through one (1) of its officers. No agent may change or waive any terms of the Policy.

CERTIFICATES

We will deliver to the Policyholder certificates of insurance to be given to each Subscriber which will state the benefits, conditions, together with the provisions concerning conversion rights, and limits of the Policy and will include any dependent coverage. Nothing in the certificate will change, modify or invalidate any of the terms and conditions of the Policy.

CLERICAL ERROR

Clerical error will not void insurance otherwise validly in force nor will it keep in force insurance which otherwise would cease.

CONFORMITY WITH LAWS

Any Policy provision which, on the Policy effective date, is in conflict with the law of the place of issue is amended to comply.

ASSIGNMENT

A Subscriber may assign all rights in and to the life insurance. An assignment will transfer the interest of the Subscriber and any Beneficiary to the assignee. Any such assignment will remain in force until changed by the assignee. No assignment will be in effect until a copy is filed with The Company. However, the assignment may be filed with the Policyholder if We agree in advance. The Company is not responsible for the validity or sufficiency of any assignment. The Beneficiary Provisions will not apply to coverage that has been assigned.

MISSTATEMENT OF AGE OR SEX

If an Eligible Person's age or sex has been misstated, an equitable adjustment will be made in the premium. If the amount of the benefit is Dependent upon an Eligible Person's age or sex, as shown in the Reduction Schedule, the amount of the benefit will be the amount an Eligible Person would have been entitled to if his or her correct age or sex were known.

WORKERS' COMPENSATION NOT COVERED

The Policy is not in lieu of Workers' Compensation coverage and does not relieve any employer of the need to provide such coverage.

LEGAL ACTIONS

No attempt to recover on the Policy through legal actions may be made until at least sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be started later than three (3) years from the time written proof of loss is required to be furnished.

TIME LIMITATIONS

If any time limit stated in the Policy for giving notice of claim or proof of loss or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Subscriber lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

REINSTATEMENT

A Subscriber's coverage may be reinstated within [three (3) months] from the date insurance ends due to an approved unpaid leave of absence. The following conditions will apply for coverage to be reinstated:

1. The Policy is still in force;
2. The Subscriber is eligible under the Policy;
3. A written request for reinstatement must be received by The Company within 31 days from the date a Subscriber returns to active status;
4. The required premium is paid; and
5. The insurability requirement, if any, is satisfied.

DUAL COVERAGE PRECLUDED

No person may be insured under this Policy as:

1. [An Employee of more than one (1) employer;]
2. A Dependent of more than one (1) Subscriber; or
3. Both a Subscriber and a Dependent.

POLICY REINSTATEMENT

In the event that this Policy is terminated because premiums were not paid within the Grace Period, We may reinstate this Policy at its sole option, and may charge an additional reinstatement fee if it wishes to do so. If The Company does not elect to reinstate this Policy, it is not required to do so.

PAN-AMERICAN LIFE INSURANCE COMPANY

CERTIFICATE OF COVERAGE

under the

Policyholder named in the Certificate Schedule of Insurance

**[GROUP TERM LIFE INSURANCE [AND
24-HOUR ACCIDENTAL DEATH [AND DISMEMBERMENT]] INSURANCE]**

**[SUPPLEMENTAL GROUP TERM LIFE [AND
24-HOUR ACCIDENTAL DEATH [AND DISMEMBERMENT]] INSURANCE]**

The Pan-American Life Insurance Company has issued a Group Policy covering certain Subscribers of the Policyholder. The benefits of the Group Policy are described in this Certificate. Final interpretation is governed by the Group Policy. This Certificate replaces any and all Certificates previously issued for the Subscribers under the Group Policy. This Certificate describes the Group Policy in effect as of the Effective Date shown in the Schedule of Insurance. This Certificate is the Subscriber's Certificate of Coverage only when the Subscriber is covered under the Group Policy.

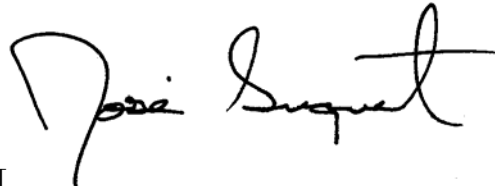
The Group Policy may be amended, changed, cancelled or discontinued without the consent of the Insured Person or the Insured Person's beneficiary.

READ THIS CERTIFICATE CAREFULLY

[30 DAY RIGHT TO RETURN THIS CERTIFICATE

If for any reason You are not satisfied with this Certificate, You may return it to The Company within 30 days after You receive it. The Company will refund any premium paid and the Certificate will be deemed void, just as though it had not been issued.]

PAN-AMERICAN LIFE INSURANCE COMPANY



[President and Chief Executive Officer]

[PARTICIPATING OR NONPARTICIPATING]

Policyholder Service Office of Company: Pan-American Life Insurance Company

Address: [601 Poydras Street, New Orleans, LA 70130]

Telephone: [1-877-939-4550]

If we at Pan-American Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department - Consumer Services Division

[1200 West Third Street

Little Rock, Arkansas 72201-1904

Telephone: (501) 371-2600]

**PAN-AMERICAN LIFE INSURANCE COMPANY
HOME OFFICE: [601 POYDRAS, NEW ORLEANS, LA 70130]**

TABLE OF CONTENTS

TITLE	PAGE
Schedule of Insurance	[X]
Monthly Premium Rates	[X]
Definitions	[X]
Eligibility Provisions	[X]
[Dependent Provisions]	[X]
Life Insurance Provisions	[X]
Conversion Privilege	[X]
Waiver of Premium Provisions	[X]
[24-Hour Accidental Death [and Dismemberment] Insurance Provisions]	[X]
Claim Provisions	[X]
Beneficiary and Settlement Provisions	[X]
Premium Provisions	[X]
General Provisions	[X]

SCHEDULE OF INSURANCE

ELIGIBLE CLASS

[All Active Full-Time Employees of the Policyholder working a minimum of thirty (30) hours per week, this does not include seasonal or temporary employees].

[All eligible Subscribers of the Policyholder.]

[Associated Companies of the Policyholder.

Effective Date: September 1, 2008]

[SERVICE WAITING PERIOD

[Employees hired before 06-01-08 are eligible for coverage on the Policy effective date].

[Employees hired on or after 06-01-08 will be eligible for coverage on the premium due date following [ninety (90) days] of continuous active employment].]

BASIC INSURANCE

Class Description	Non-Contributory	
	[Life Amount]	[Accidental Death [and Dismemberment] Principal Sum
[All Eligible Classes]	[\$10,000.00]	[\$10,000.00]]

Amount of insurance reduces to 65% at age 65, to 40% of the original amount at age 70, to 25% of the original amount at age 75; benefit terminates at retirement.

[SUPPLEMENTAL TERM LIFE INSURANCE]

Class Description	Contributory	
	Supplemental Life Amount	
[All Eligible Classes]	[Increments \$1,000 units up to \$100,000, as elected]	
[All Eligible Classes with Subscribers:	[Under 65:]	[Increments of \$1,000 units up to \$25,000, as elected]
	[65 and older:]	[Increments of \$1,000 units up to \$10,000, as elected]
[All Eligible Classes with Subscribers between the ages of [18] and [64] subject to evidence of insurability]	[Increments \$1,000 units up to \$100,000, as elected]	

[SUPPLEMENTAL ACCIDENTAL DEATH [AND DISMEMBERMENT] INSURANCE]

Class Description	Contributory Supplemental Accidental Death [and Dismemberment] Amount
[All Eligible Classes]	[Increments \$1,000 units up to \$100,000, as elected]
[All Eligible Classes with Subscribers: [Under 65:] [65 and older:]	[Increments of \$1,000 units up to \$25,000, as elected] [Increments of \$1,000 units up to \$10,000, as elected]
[All Eligible Classes with Subscribers between the ages of [18] and [64] subject to evidence of insurability]	[Increments \$1,000 units up to \$100,000, as elected]

1

DEPENDENT LIFE INSURANCE

Coverage for Dependents is applicable only if elected and the required premiums have been paid.

<u>Class</u>	<u>Benefit Amount</u>
Spouse	[\$2,000.00]
Child(ren) 14 days to 6 months	[\$1,000.00]
6 months to age [19] (to age [25] if a Full-Time student)	[\$1,000.00]

1

MONTHLY PREMIUM RATES

The initial monthly premium rates as of the Policy Effective Date for the coverages provided by this Policy are as on file with The Company and the Policyholder.

DEFINITIONS

[ACTIVE WORK and ACTIVELY AT WORK means an Employee is Actively At Work with the Policyholder on the day insurance becomes effective, which is one of the Policyholder's scheduled work days if:

1. the Employee is performing his or her regular occupation at the Policyholder's usual places of business or at some location to which the Policyholder's business requires the Employee to travel; or
2. the day is a scheduled holiday, vacation day or period of Policyholder approved paid leave of absence.

An Employee is considered Actively At Work on a day, which is not one of the Policyholder's scheduled workdays only if the Employee was actively at work on the last preceding scheduled work day.

A person other than an Employee is considered Actively At Work if able to perform all activities another person of the same age and sex could normally perform and is not:

1. a patient in a hospital or hospice, or receiving outpatient care for chemotherapy or radiation therapy;
2. confined at home under the care of a Physician for sickness or injury;
3. unable to perform any of the activities of daily living expected of a person of the same age; e.g., mobility, transferring, feeding; without human supervision or assistance; or
4. receiving disability benefits from any source due to Sickness or Injury.]

AFFILIATE or SUBSIDIARY means a company, corporation, partnership, or person named as such in the Policyholder's application for coverage under the Policy. Such firms must be under the control of the Policyholder through ownership, contract or other arrangement. Any records of such firm which have a bearing on the insurance provided in the Policy will be deemed to be records of the Policyholder. If an Affiliated or Subsidiary firm ceases to be under the control of the Policyholder, the insurance of the Insured persons of such firm will automatically cease on the date of such change, whether or not the change is reported to Us.

The inclusion of the Policyholder's Affiliated or Subsidiary firm will have no effect on the Policyholder's rights under this Policy.

[APPLIES ONLY TO EMPLOYER SUPPLEMENTAL GROUP TERM LIFE INSURANCE.

ANNUAL ENROLLMENT PERIOD means the period in each calendar year when an eligible Subscriber may change benefit elections under the policy. Both the Policyholder and The Company must agree upon this period.]

[CONTRIBUTORY means the Subscriber pays either all or part of the cost of the insurance.]

DISABLED OR DISABILITY refers to any Disability which results from a Sickness or Injury that prevents the Subscriber from engaging in any gainful business or occupation for which the Subscriber is or could become reasonably qualified by reason of education, training, or experience. The Subscriber must be under the regular care and treatment of a Physician other than themselves.

[DOMESTIC PARTNER means a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Subscriber has established a Domestic Partnership. In no event, will a person's legal spouse be considered a Domestic Partner.]

[DOMESTIC PARTNERSHIP means a relationship between the Subscriber and one other person of the [opposite sex] [same sex] [opposite or same sex]. The following requirements apply to both persons:

1. [They share the same permanent residence and the common necessities of life;
2. They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
3. Each is at least 18 years of age;
4. Each is mentally competent to consent to contract;
5. Neither is currently married to, or Domestic Partner of, another person under either a statutory or common law;
6. They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:

- a. have a single dedicated relationship of at least 6 months duration;
 - b. joint ownership of residence;
 - c. at least two of the following:
 - i. joint ownership of an automobile;
 - ii. joint checking, bank or investment account;
 - iii. joint credit account;
 - iv. lease for a residence identifying both partners as tenants;
 - v. a will and/or life insurance policies which designates the other as primary beneficiary.
7. The Subscriber and Domestic Partner must jointly sign an affidavit of Domestic Partnership.]

ELIGIBLE PERSON means an employee of the Policyholder or other person whose connection with the Policyholder meets the eligibility requirements specified in both the application and the Policy.

[**EMPLOYEE** means any person who works for the Policyholder at the Policyholder's place of business and whose income is reported for tax purposes using a W-2 form.]

EVIDENCE OF INSURABILITY means an Eligible Person will satisfy the insurability requirement on the day The Company agrees in writing to accept the person as insured for that amount. To determine a person's acceptability for coverage, The Company will require evidence of good health and may require it to be provided at the Insured Person's expense.

[**FULL-TIME EMPLOYEE** means any person who is regularly scheduled to work for the Employer for at least thirty (30) hours per week, at the Employer's usual place or places of business.]

INJURY means accidental loss or bodily harm, which results directly and independently of all other causes from the accident. All injuries that are suffered in one accident are considered to be one injury.

INSURED PERSON means the Subscriber [or an enrolled Dependent,] who is eligible for coverage under the Policy for whom insurance is elected, the required premium is paid, and coverage is in force under the Policy.

[APPLIES ONLY TO SUPPLEMENTAL GROUP TERM LIFE INSURANCE]

LIFE STATUS CHANGE a Life Status Change is an event qualifying a Subscriber to make changes in benefit selections at a time other than an Annual Enrollment Period. The following events are Life Status Changes.

1. Marriage
2. Divorce, annulment or legal separation
3. Birth or adoption of a child
4. Death of a spouse
5. Termination of a spouse's employment
6. A change in the benefit plan available to the Subscriber's Spouse
7. [A change in the employment status of the Employee or the Employee's Spouse that affects either person's eligibility for benefits].]

[**NON-CONTRIBUTORY** means the Subscriber does not pay any part of the cost of the insurance.]

PHYSICIAN means a licensed Doctor of Medicine (MD) or Osteopathy (DO). The term does not include the Subscriber, Subscriber's spouse, or the immediate family of the Subscriber (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in the Subscriber's household.

POLICYHOLDER means the entity or other organization to whom this Policy is issued.

[**SERVICE WAITING PERIOD** means the period of time that begins with the Employee's most recent date of employment and ends on the day prior to the day the Employee is eligible for coverage under the Policy.]

SICKNESS means physical or mental illness or disease.

SUBSCRIBER means an Eligible Person who is properly enrolled for coverage under the Policy. The Subscriber is the person [(who is not a Dependent)] on whose behalf the Policy is issued to the Policyholder.

WE/US/OUR/THE COMPANY means Pan-American Life Insurance Company.

ELIGIBILITY PROVISIONS

ELIGIBLE CLASSES

WHEN A SUBSCRIBER BECOMES ELIGIBLE

A person becomes eligible for the coverage provided by the Policy on [the later of the following:

1. [The Policy's Effective Date]; or
2. The date the person completes the Service Waiting Period.]

EFFECTIVE DATE

Insurance becomes effective on the latest of the following:

1. The first day of the month following the date that the person becomes eligible for the coverage;
2. [The date the person resumes Active Work, if not Actively At Work on the day such person became eligible;]
3. The date the person's evidence of insurability is approved by The Company, if required.

EVIDENCE OF INSURABILITY

The Company requires satisfactory evidence of insurability when:

1. The Company's underwriting guidelines requires it;
2. The person makes written application for insurance more than 31 days after becoming eligible for coverage;
3. The person makes written application for insurance after requesting to cancel insurance[; or
4. The person makes written application to increase Supplemental Group Term Life Insurance [by more than 1 level(s) of coverage].]

CHANGES IN AMOUNT OF INSURANCE

Any increases in the amount of a Subscriber's insurance will take effect on the first day of the month coinciding with or following the date of increase.

Decreases in the amount of a Subscriber's insurance will take effect on the first day of the month following the date of change.

[Applies only to employer Supplemental Group Insurance]

During an Annual Enrollment Period, or within 31 days after a Life Status Change, a Subscriber currently insured for Supplemental Group [Term Life] Insurance may increase his or her Supplemental Group [Term Life] Insurance benefits [by one (1) level] without submitting evidence of insurability.]

TERMINATION OF INSURANCE

A Subscriber's coverage will end on the earliest of the following dates:

1. The date the Subscriber is no longer eligible;
2. The date such Subscriber enters the armed services for any state or country on active duty; except for duty of thirty (30) days or less for training in the Reserves or National Guard;
3. The date the Policy terminates;
4. The day after the end of the period for which premiums are paid;
5. The last day of the month in which the Subscriber requests termination;
6. [The last day of the Policy month following the date the Subscriber ceases to be Actively At Work, except if the Subscriber ceases Active Work as a result of:
 - a. A temporary layoff or leave of absence. The life insurance may be continued until the Policyholder stops paying premium for the Subscriber or otherwise cancels the insurance. Such insurance will not continue for more than three (3) months past the Subscriber's last day of Active Work. Upon written request from the Policyholder, We may agree in writing to continue the Subscriber's insurance for an additional number of months during lay-off or leave of absence.
 - b. Injury or Sickness. The life insurance may be continued while the Subscriber remains totally Disabled as a result of the Injury or Sickness. Such insurance will not continue past the earlier of:
 - i. six (6) months from the date the Subscriber was no longer Actively At Work unless the Policyholder obtains the consent of The Company in writing for a longer period; or

- ii. the date the Policyholder stops paying premium for the Subscriber or otherwise cancels the insurance. The Subscriber may pay the premium to the Policyholder during this period in order to continue coverage during Injury or Sickness.
- c. Labor dispute. The basic life insurance will be continued for those Insured Persons who elect to pay the premium to the Policyholder. Such insurance will not continue for more than six (6) months past the Subscriber's last day of Active Work.]

[FAMILY CARE LEAVE

If the Employer is subject to the Family & Medical Leave Act of 1993 and the Subscriber's approved leave of absence is for family care pursuant to the Act, payment of premium for the Subscriber shall keep coverage in effect for the duration(s) prescribed by the Act. The Employer is solely responsible for notifying the Subscriber of the availability and duration of family leaves.]

DEPENDENT PROVISIONS

ELIGIBILITY

Each Subscriber becomes eligible for Dependent's insurance on the later of:

1. the date the Subscriber becomes insured; or
2. the effective date of Dependent Insurance; or
3. the date the Subscriber first acquires a Dependent.

ELIGIBLE DEPENDENTS

A Subscriber's Dependents include:

1. A spouse who is not legally separated or divorced and is less than age [70]. [All references to the spouse of a Subscriber shall include a Domestic Partner.]
2. An unmarried natural or legally adopted child:
 - a. from [14 days] to [19] years; or
 - b. [19] years but less than [25] years old and enrolled as a full-time student in an accredited college or university.
 - c. who is [19] or more years of age, primarily supported by the Subscriber, incapable of self-support by reason of mental or physical handicap. Proof of the condition and dependent must be submitted to Us within 31 days after the child ceases to qualify as a Dependent. We may, during the next two (2) years, from time to time, require proof of the continued condition and dependence. Thereafter, We may require proof no more than once a year.

The term "child" means a child born to or legally adopted by the Subscriber; a child for whom the Subscriber is the legal guardian; or a child placed with the Subscriber for the purpose of adoption. It also means a stepchild, foster child, or other child who depends upon the Subscriber for support and lives with the Subscriber in a regular parent/child relationship.

A Dependent does not include:

1. anyone enrolled under the Policy as a Subscriber; or
2. anyone serving in the Armed Forces for any state or county, except for duty of thirty (30) days or less for training in the Reserves or National Guard.

EFFECTIVE DATE

The Subscriber's Dependent insurance for each Dependent will become effective on the latest of:

1. the date the Subscriber becomes eligible for Dependent insurance;
2. the date The Company approves any required evidence of insurability on each Dependent of the Subscriber;
3. the date following the date an eligible Dependent, other than a newborn child, is discharged from house confinement, or hospital or other health care facility and resumes the normal activities of someone of like age and sex;
4. the date a Dependent child placed with the Subscriber for adoption while this coverage is in force. Such coverage will continue, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

TERMINATION OF DEPENDENT'S INSURANCE

The Dependent insurance of a Dependent will cease on the earliest of the following dates:

1. 31 days after the end of the period for which premiums have been paid;
2. the date Dependent insurance terminates;
3. the date the Subscriber's insurance under the Policy terminates;
4. the date the Dependent ceases to be a Dependent as defined in this Policy; or
5. the date the coverage under the Policy is canceled.

LIFE INSURANCE PROVISION

DEATH BENEFITS

We will pay the Insured Person's beneficiary the amount of insurance in force on the date of death when We receive satisfactory proof of the Insured Person's death. The benefit will be paid in accordance with the Beneficiary Provision.

SETTLEMENT OPTIONS

Instead of a single lump sum payment, the Insured Person may choose to have all or part of the insurance paid under one of the settlement options We have available. [We will give the Insured Person full information about the options upon request.]

SUICIDE LIMITATIONS

If an Insured Person's death occurs by suicide, while sane or insane, within 2 years of the Insured Person's Effective Date the only benefit payable will be a refund of the premiums which have been paid for the Insured Person.

CONVERSION PRIVILEGE

An individual life policy, known as a conversion policy, may be purchased through The Company without evidence of insurability if all or part of a Subscriber's life insurance terminates for any reason except non-payment of premium.

Application and payment of the first premium must be made to The Company within 31 days after coverage under the Policy ends.

Any policy issued will be for an amount not to exceed the amount of life insurance which was terminated. It may be on any form provided by The Company, except term, without disability or other supplemental benefits. Premium for the conversion insurance will be based on the Subscriber's age and class of risk, and the type and amount of coverage issued. The policy will not cover Dependents.

CONVERSION UPON TERMINATION OR AMENDMENT OF POLICY

If this Policy terminates or is amended to terminate any class of Subscribers, or the Policyholder cancels participation under the Policy, coverage cannot be converted unless the individual has been insured under the Policy for at least five (5) years. The amount of conversion insurance will be the lesser of the amount of life insurance in force under the Policy, or **\$10,000**.

INSURANCE CONTINUED UNDER GROUP POLICY

If the Subscriber has converted to an individual Policy and again becomes insured under this Group Life Policy, the individual Policy must be returned to Us before the Subscriber may be insured under this Policy.

DEATH DURING CONVERSION PERIOD

If a Subscriber dies within the thirty-one (31) day conversion period, We will pay the death benefit whether or not the Subscriber applied for conversion insurance. If the first premium was paid for the conversion policy, the amount of premium paid will be refunded and the conversion will be void.

WAIVER OF PREMIUM PROVISIONS

BENEFIT

If a Subscriber becomes totally Disabled while insured under the Policy and is under age 60, We will continue life insurance without payment of premium.

We must receive proof that the Subscriber:

- 1 has been continuously Disabled for [six, nine, or twelve] months; and
- 2 was continuously insured for at least [twelve (12) months] under this Policy prior to becoming Disabled.

Notice of satisfactory proof of Disability must be submitted no later than three (3) months after the Subscriber has been continuously Disabled for [six, nine, or twelve] months. Premiums will be waived from the date The Company agrees in writing to waive premiums. The Company will refund up to twelve (12) months of premiums that were paid after the date the Subscriber became totally Disabled.

CONTINUATION OF WAIVER OF PREMIUM

The Waiver of Premium benefit will be extended for succeeding periods of one (1) year if the Subscriber submits satisfactory proof to Us that Disability continue during the three (3) months before the end of the one (1) year period.

During the two (2) years following the initial proof of total Disability, We may require at reasonable intervals and at Our own expense, a physical examination that the Disability continues. Thereafter, proof will not be required more often than once a year.

If a Subscriber dies during this period, We will pay the benefit in effect on the day the Subscriber became Disabled, subject to the provisions of the Policy that may reduce or terminate coverage on account of age, retirement, acceleration or a change in eligible class.

TERMINATION OF WAIVER OF PREMIUM

Insurance will end for any Subscriber whose premiums are waived on the earliest of the following dates:

1. The date the Subscriber is no longer Disabled;
2. The date the Subscriber refuses to submit to any examination required by the Company;
3. The date the Subscriber fails to submit satisfactory proof of continued Disability;
4. The date the Subscriber attains age sixty-five (65);
5. The date the Subscriber retires[;]
6. The date the Subscriber accepts employment or is found able to accept employment for which the Subscriber is reasonable fitted by training, education or experience].

Insurance will not be affected by termination or amendment of the Policy after the Subscriber becomes totally Disabled.

[CONTINUATION OF DEPENDENT LIFE INSURANCE

We will continue the Subscriber's Dependent Life insurance without payment of premium provided:

1. the Dependent insurance was in force prior to the Subscriber becoming Disabled; and
2. the Subscriber continues to satisfy the terms of this provision.

Dependent Insurance will end for any Subscriber whose premiums are waived when the first of the following occurs:

1. the Subscriber 's premiums are no longer being waived;
2. the Subscriber fails to meet the terms of this Policy;
3. the Subscriber is no longer Disabled;
4. the Dependent insurance provided under this Policy is terminated; or
5. the Subscriber dies.

PORTABILITY

Portability is the Subscriber's right to continue insurance at the time insurance ends. [It does not apply to Basic Life Insurance Benefit [or the Accidental Death [and Dismemberment] Benefit].] Coverage continued under this provision is subject to all other provisions and limitations of the Policy.

ELIGIBILITY

A Subscriber may continue insurance if coverage ends for any reason other than termination of the Policy, is under age [70], and has been continuously covered under the Policy for at least [12] months prior to the date insurance terminates. Insurance may not be continued if the Subscriber's coverage terminates due to disability or retirement.

AMOUNT OF INSURANCE

The Subscriber may continue insurance up to the amount terminated under the Policy. Waiver of Premium [and Accelerated Death Benefits are] not available. The Subscriber must submit an application to The Company and pay the required premium. The Subscriber may not elect to port coverage at a later date, if the Subscriber does not elect to continue insurance within 31 days after coverage ends

PREMIUM

The premium for this coverage will be based on the rate in force for the Policy. The required premium will be at the rates that are on file with The Company and the Policyholder.

LIMITATIONS AND TERMINATION

Coverage continued is subject to the following conditions:

1. Coverage will terminate when The Company cancels coverage for all members of the Subscriber's class;
2. Coverage will terminate the date after the end of the period for which premiums are paid;
3. Insurance terminates at age [70];
4. Coverage will terminate when the Policy terminates;
5. Conversion Privilege will apply if coverage ends due to reaching the termination age;
6. If coverage lapses due to nonpayment of premium, Conversion Privilege will not apply.

24-HOUR ACCIDENTAL DEATH [AND DISMEMBERMENT] INSURANCE

If, within [ninety (90)] days from the date of an accident covered by this Policy, bodily Injuries result in any of the following losses, We will pay the benefits shown opposite such loss.

[Only one amount will be paid if the Subscriber sustains more than one loss as the result of any one accident. We will pay only the largest benefit amount to which the Subscriber is entitled.] This amount will not exceed the Principal Sum shown in the Schedule.

Payment will be made to the Subscriber, or in the event of Subscriber's death, to the named Beneficiary.

Loss of Life	Principal Sum
[Loss of Both Hands or Both Feet	Principal Sum
Loss of Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Sight of One Eye	Principal Sum
Loss of One Foot and Sight of One Eye	Principal Sum
Loss of One Hand	One-half Principal Sum
Loss of One Foot	One-half Principal Sum
Loss of Sight of One Eye	One-half Principal Sum]

[Loss of foot or hand means complete severance through or above the ankle or wrist joint. Loss of an eye means total and irrecoverable loss of sight. Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joints (the joins between the fingers and the hand).]

EXCLUSIONS AND LIMITATIONS

We will not pay for any loss to a Subscriber which results directly or indirectly, wholly or partly from:

1. [Suicide or attempted suicide, while sane or insane;]
2. [Self-destruction while sane or insane within two years from the date of issue of the Policy.]
3. [Intentionally self inflicted injury, while sane or insane;]
4. [Commission of a felony;]
5. [War or any act of war, whether declared or undeclared, terrorism, insurrection, rebellion, or participation in a riot or civil commotion;]
6. [Travel or flight in any vehicle for aerial navigation, including boarding or alighting therefrom;
 - a. while being used for any test or experimental purpose; or
 - b. while the Subscriber is operating, learning to operate or serving as a member of the crew thereof.]
7. [Sickness, disease or bodily infirmity. (This does not include bacterial infection, which results from an accidental cut or wound or accidental ingestion of a poisonous food substance.)]
8. [Taking a poison, or asphyxiation from or inhaling of gas, or intentionally taking narcotics, drugs, barbiturates, hallucinogenic drugs, alcohol or any combination of these when not part of a professional medical treatment.]
9. [Bodily injuries received while the Subscriber was operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit;]
10. [Accident occurring while the Subscriber is serving on full-time active duty in any Armed Forces or in any ambulance, medical, hospital, or civilian noncombatant unit service with such forces, either while serving with or within six months after termination of service in such forces or units; (any premium paid will be returned by Us pro-rata for any period of active-full time duty);]
11. [An injury caused by, or due to, prolonged exposure to dangerous substances, cumulative trauma, or repetitive motion;]
12. [Within two years from the date of issue of the Policy as a result of a specified hazardous occupation or occupations or while the Subscriber is residing in a specified foreign country or countries;]
13. [engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping or using off-road vehicles;]

CLAIM PROVISIONS

NOTICE OF CLAIM

Written notice of claim must be given to The Company within 31 days after a covered loss occurs or begins. If this notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible. The notice must be sent to The Company at its Home Office and should include the Subscriber's name, address, city, state, zip, and policy number.

CLAIM FORMS

The Company will send the claim forms to the Subscriber upon receipt of notice of claim. If the Subscriber does not receive these forms within 15 days, the proof of loss requirement may be met by giving The Company a written statement of the nature and extent of the loss within the time limit stated below.

PROOF OF LOSS

The Company requires written proof of loss within ninety (90) days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one (1) year from such time unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIM

Any benefits payable will be paid when The Company receives proper written proof of loss.

PHYSICAL EXAMINATION AND AUTOPSY

We, at Our own expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. We will also have the right to have any autopsy performed unless prohibited by law.

BENEFICIARY AND FACILITY OF PAYMENT PROVISIONS

Upon receipt of satisfactory proof of the Covered Person's death, The Company will pay the benefits, to the Beneficiary, if any, on file. If there is no designated or specified beneficiary, insurance will be payable to the Covered Person's estate or to one or more of the following surviving relatives:

1. Wife, husband;
2. Child, children;
3. Mother, father;
4. Brothers, sisters.

If the Covered Person's designated beneficiary dies:

1. within [15 days] of the Covered Person's death; and
 2. before The Company receives satisfactory proof of the Covered Person's death,
- payment will be made as if the Covered Person had survived such beneficiary unless provisions have been made. The right of a beneficiary to receive any such amount is subject to the Facility of Payment provision.

BENEFICIARY DESIGNATION

Each beneficiary will be as shown on the Subscriber's application, unless changed. If there is more than one beneficiary named, they will share equally unless otherwise specified in writing.

CHANGING THE BENEFICIARY

A Subscriber may change a Beneficiary at any time by giving written notice to The Company. The beneficiary's consent is not required for this or any other change the Subscriber may make unless the beneficiary designation is irrevocable. Once received by The Company, the change will take effect as of the date on the request. If the Subscriber dies before the request is received The Company will not be liable for any payment that was made before receipt of the request.

FACILITY OF PAYMENT

If any benefit under the Policy becomes payable to:

1. A Covered Person's estate;
 2. A minor, or
 3. Any person who, in the opinion of The Company, is not competent to give a valid release;
- then The Company, at its option, may make payment to any one or more the following:
- a. A person who has assumed the care and support of the Covered Person or beneficiary;
 - b. A person who has incurred funeral or other expenses as a result of the Covered Person's last illness or death;
 - c. The personal representative of the Covered Person's estate;
 - d. Any person related to the Covered Person by blood or marriage.

No payments made to anyone named above may exceed \$250, or the maximum allowed by state law. Any payment made in good faith under this section will fully discharge The Company to the extent of the payment.

PREMIUM PROVISIONS

PREMIUM PAYMENT

Premiums are payable at the Home Office of The Company on or before each premium due date.

PREMIUM DUE DATE

The first premium will be due on the Policy effective date and on the same day of each subsequent month unless the Policyholder and The Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period.

CHANGES IN PREMIUM RATES

The monthly premium rates may be changed by Us from time to time if We give the Policyholder at least thirty-one (31) days advance written notice. No such change will be made until twelve (12) months after the Policy effective date except when the Policyholder requests it.

INCORRECT PREMIUM PAYMENT

Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has ceased, will be refunded without interest when requested by the Policyholder. These premiums will not be refunded for any period before the last anniversary date.

GRACE PERIOD

If, before any premium due date except the first, the Policyholder has not given written notice to The Company that the Policy is to be terminated, a Grace Period of thirty-one (31) days will be given in which to pay the premium then due. The Policy will stay in effect during that time. If any premium is not paid by the end of the Grace Period, the Policy will automatically terminate at the end of the Grace Period; except that if the Policyholder has given written notice in advance of an earlier date of termination, the Policy will terminate as of the earlier date.

NOTICE OF CANCELLATION

The Policyholder or The Company may cancel the Policy as of any Premium Due Date by giving 31 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period.

AVERAGE PREMIUM RATE

As of the date of issue, We will compute an average premium rate per \$1,000.00 of insurance. This rate will be determined by applying the individual rates to the amounts of insurance in force at the respective ages and nearest birthday of all Subscribers, and dividing the aggregate by the total amount of insurance with adjustments for any applicable discounts or loadings. On any Policy anniversary or on any day on which the Policy is amended, either the Policyholder or The Company may require that the average premium rate be recomputed prospectively according to the then attained ages of the insured Subscriber and the table of individual rates then in force (excluding those amounts continued by virtue of the Death During Conversion Period and the Waiver of Premium Provision).

AMOUNT OF PREMIUMS

Each premium shall be equal to the product of the total amount of insurance (excluding those amounts continued by virtue of the Death During Conversion Period and the Waiver of Premium Provisions) in force on the due date, and the average premium rate then in effect. However, any other method may be used which produces approximately the same total amount and which is mutually agreeable to the employer and Us.

GENERAL PROVISIONS

EXECUTION OF POLICY

The Policy is executed at the Home Office of Pan-American Life Insurance Company in New Orleans, Louisiana.

CONSIDERATION

The Policy is issued to the Policyholder in consideration of the application and payment of premiums.

INSURANCE DATA

The Policyholder will give The Company all of the data that it needs to administer the Policy. We have the right to examine the Policyholder's records relative to these benefits at any time while the Policy is in force. It also has the right until all rights and obligations under the Policy are finally determined.

ADMINISTRATION

We will deal solely with the Policyholder who will be deemed to be acting as an agent for each Subscriber. Any action taken by the Policyholder will be binding on the Subscriber.

INCONTESTABILITY

We will not contest the Policy after two (2) years from the date of onset of issue except for failure to pay premium. No statement made by an Eligible Person will be used to deny a claim after the person's coverage has been in force for a period of two (2) years during the Eligible Person's life; then only if the statement is made in writing and signed by the Eligible Person.

STATEMENT NOT WARRANTIES

All statements made by the Policyholder or by an Eligible Person will, be deemed representations and not warranties. No statement made by the Policyholder or by the Eligible Person to obtain insurance will be used to avoid or reduce the insurance unless:

1. It is made in writing;
2. It is signed by the Policyholder or the Eligible Person; and
3. A copy is sent to the Policyholder, the Eligible Person or the Eligible Person's Beneficiary.

ENTIRE CONTRACT

The entire contract will be made up of the Policy, Certificates, the application of the Policyholder, any individual Subscriber applications, Amendments and Riders will constitute the entire Policy between parties.

POLICY CHANGES

Changes may be made in the Policy only by amendment signed by the Policyholder and by The Company acting through one (1) of its officers. No agent may change or waive any terms of the Policy.

CERTIFICATES

We will deliver to the Policyholder certificates of insurance to be given to each Subscriber which will state the benefits, conditions, together with the provisions concerning conversion rights, and limits of the Policy and will include any dependent coverage. Nothing in the certificate will change, modify or invalidate any of the terms and conditions of the Policy.

CLERICAL ERROR

Clerical error will not void insurance otherwise validly in force nor will it keep in force insurance which otherwise would cease.

CONFORMITY WITH LAWS

Any Policy provision which, on the Policy effective date, is in conflict with the law of the place of issue is amended to comply.

ASSIGNMENT

A Subscriber may assign all rights in and to the life insurance. An assignment will transfer the interest of the Subscriber and any Beneficiary to the assignee. Any such assignment will remain in force until changed by the assignee. No assignment will be in effect until a copy is filed with The Company. However, the assignment may be filed with the Policyholder if We agree in advance. The Company is not responsible for the validity or sufficiency of any assignment. The Beneficiary Provisions will not apply to coverage that has been assigned.

MISSTATEMENT OF AGE OR SEX

If an Eligible Person's age or sex has been misstated, an equitable adjustment will be made in the premium. If the amount of the benefit is Dependent upon an Eligible Person's age or sex, as shown in the Reduction Schedule, the amount of the benefit will be the amount an Eligible Person would have been entitled to if his or her correct age or sex were known.

WORKERS' COMPENSATION NOT COVERED

The Policy is not in lieu of Workers' Compensation coverage and does not relieve any employer of the need to provide such coverage.

LEGAL ACTIONS

No attempt to recover on the Policy through legal actions may be made until at least sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be started later than three (3) years from the time written proof of loss is required to be furnished.

TIME LIMITATIONS

If any time limit stated in the Policy for giving notice of claim or proof of loss or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Subscriber lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

REINSTATEMENT

A Subscriber's coverage may be reinstated within [three (3) months] from the date insurance ends due to an approved unpaid leave of absence. The following conditions will apply for coverage to be reinstated:

1. The Policy is still in force;
2. The Subscriber is eligible under the Policy;
3. A written request for reinstatement must be received by The Company within 31 days from the date a Subscriber returns to active status;
4. The required premium is paid; and
5. The insurability requirement, if any, is satisfied.

DUAL COVERAGE PRECLUDED

No person may be insured under this Policy as:

1. [An Employee of more than one (1) employer;]
2. A Dependent of more than one (1) Subscriber; or
3. Both a Subscriber and a Dependent.

POLICY REINSTATEMENT

In the event that this Policy is terminated because premiums were not paid within the Grace Period, We may reinstate this Policy at its sole option, and may charge an additional reinstatement fee if it wishes to do so. If The Company does not elect to reinstate this Policy, it is not required to do so.

[

CERTIFICATE SCHEDULE OF INSURANCE

Policy Number: G-123456
Policyholder Name: ABC Group
Effective Date: June 1, 2008

Insured: John Doe
Dependent Coverage: ☐ Yes ☐ No
Beneficiary: As on file with The Company

Coverage:

Term Life Insurance Benefit Amount: \$10,000

24-Hour Accidental Death and Dismemberment Principal Sum: \$10,000

Supplemental Term Life Insurance Benefit Amount: \$25,000

24- Hour Accidental Death and Dismemberment Principal Sum: \$25,000

Optional Accidental Benefits: ☐ Yes ☐ No

Optional Accelerated Death Benefit: ☐ Yes ☐ No

]

PAN-AMERICAN LIFE INSURANCE COMPANY
[601 POYDRAS
NEW ORLEANS, LOUISIANA 70130]

AMENDATORY RIDER

This amendatory rider becomes a part of and is effective on the same date as the Policy and Certificate to which it is attached.

[COMMON CARRIER BENEFIT (PUBLIC TRANSPORTATION)]

If the Subscriber suffers a covered loss while insured under the Policy as a result of a covered accident which occurs as a fare-paying passenger on a public transportation vehicle, We will pay additional Common Carrier Benefit equal to the lesser of:

1. the Subscriber's full amount of Accidental Death [and Dismemberment] insurance; or
2. [\$5,000]

"Common Carrier" means a government regulated entity that is in the business of transporting fare-paying passengers. This does not include chartered or other privately arranged transportation, taxis or limousines.]

[SEAT BELT [AND AIR BAG] BENEFIT]

The Company will pay an additional Benefit if the Subscriber dies as a result of a motor vehicle accident while covered under the Policy and while driving or riding as a passenger in an automobile.

We will pay [:

- 1.] A Seat Belt Benefit equal to the lesser of [10%] of the amount of the Subscriber's full Accidental Death benefit or [\$10,000] [; or
2. A Seat Belt and Air Bag Benefit equal to the lesser of [20%] of the amount of the Subscriber's full Accidental Death Benefit or [\$20,000].]

This Seat Belt benefit is in addition to the Accidental Death Benefit and will be paid when The Company receives proof that:

1. The Subscriber's death was a result of the accident;
2. The Subscriber died while coverage under the Policy was in force;
3. The Subscriber died within one year of the accident;
4. The automobile was equipped with seat belts at the time of the accident;
5. The Subscriber's seat belt was in actual use and was properly fastened at the time of the accident;
6. Position of the seat belt is certified in the official accident report, or by the investigating officer.

[An additional Air Bag benefit will be paid if:

1. The Seat Belt benefit is payable; and
2. The automobile is equipped with a single air bag and the Subscriber is the driver; or
3. The automobile is equipped with an air bag for both the driver and for the front passenger seat and the Subscriber is the driver or front passenger; or
4. The automobile is equipped with an air bag for both the driver seat, front seat passenger, or rear seat passenger; and
5. The police report or other evidence establishes that the air bag inflated properly upon impact.]

This Benefit is not payable under this provision if:

1. The Subscriber is either the passenger or the driver, and the driver was legally intoxicated or under the influence of drugs at the time of the accident; or
2. The driver did not hold a current or valid driver's licenses at the time of the accident.

A copy of the police report must be submitted with the claim. If such certification is not available, and it is unclear whether the Subscriber was wearing a seat belt, The Company will pay a fixed benefit equal to [\$1,000] to the Beneficiary.

["Air Bag" means a supplemental restraint system that inflates for added protection to the head and chest areas. The air bag must meet published federal safety standards, be installed by the car manufacturer or consist of proper replacement parts as required by the car manufacturer's specifications and not have been altered after such installation.]

"Automobile" means a motor vehicle licensed for use on public highways.

“Seat Belt” means a properly installed combination lap and shoulder restraint system that meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration. Seat belt will include a lap belt alone, but only if the automobile did not have a combination lap and shoulder restraint system when manufactured. Seat belt does not mean a shoulder restraint alone.]

/SPECIAL EDUCATION BENEFIT

If the Subscriber dies as a result of a covered accident while insured under the Policy and is survived by one or more dependent children, to a maximum of four (4) children, an additional Special Education Benefit will be paid.

Each dependent child will receive reimbursement for incurred educational expenses if enrolled as a full-time student at an accredited school of higher learning before reaching age 25. The benefit will be the lesser of [2%] of the Subscriber’s full Accidental Death Benefit or [\$2,000] each year for four years as long as the child provides proof that they continue to be enrolled as a full-time student at an Institute of Higher Learning.

If at the time of accident no dependent qualifies, The Company will pay a fixed equal to [\$1,000] to the designated Beneficiary.

“Institute of Higher Learning” includes universities, colleges, trade schools, and professional schools; it does not include graduate programs.]

/SPOUSE RETRAINING BENEFIT

If the Subscriber dies as a result of and within [one year] of a covered accident while insured under the Policy, We will pay an additional Spouse Retraining Benefit.

The spouse will be reimbursed [up to \$3,000] for actual costs of educational expenses incurred when enrolling within [one year] of the Subscriber’s death in an accredited school for the purpose of retraining or refreshing skills needed for employment.]

/FELONIOUS ASSAULT BENEFIT

If the Subscriber dies [or suffers a covered dismemberment] as a result of a covered accident while insured under this Policy which is the result of a felonious assault, The Company will pay an additional Felonious Assault Benefit equal to the lesser of [10% of the Subscriber’s Principal Sum or \$25,000].

“Felonious Assault” means a physical attack by another person resulting in bodily harm. A physical attack is any willful or unlawful use of force or violence with the intent to cause bodily injury. The physical attack must be considered a felony or misdemeanor in the jurisdiction in which it occurs. The felonious assault must not be either a moving violation as defined under the applicable state motor vehicle laws or an act of an immediate family member of the Subscriber or a person residing with the Subscriber.]

/SPOUSE CRITICAL PERIOD BENEFIT

If the Subscriber dies as a result of a covered accident while insured under the Policy and is survived by a Dependent spouse, an additional Spouse Critical Period benefit will be paid.

We will pay a monthly benefit to the surviving spouse equal to [1%] of the Subscriber’s full amount of Accidental Death insurance not to exceed [12 consecutive months]. Payments will commence upon approval of the Subscriber’s accidental death claim. If the surviving spouse dies within the [12 month] period, benefits will end.

[For this benefit to be payable to a Domestic Partner, the Subscriber must designate him or her, in writing, as a Beneficiary.]]

/EXPOSURE BENEFIT

If the Subscriber is unavoidably exposed to the elements by reason of a covered accident and suffers a loss that is included in the list of covered losses as a result of such exposure, such loss will be covered under the terms of this Policy.]

/DISAPPEARANCE BENEFIT

If the Subscriber's body has not been found after one year from the date the vehicle in which the Subscriber was traveling, disappeared, exploded, sank, became stranded, made a forced landing or was wrecked, it shall be presumed, subject to all other terms of the policy, that the Subscriber has died as a result of an accidental Injury which was unintended, unexpected and unforeseen. Such death will be covered under the terms of this Policy.]

/FAMILY THERAPY or THERAPEUTIC COUNSELING BENEFIT

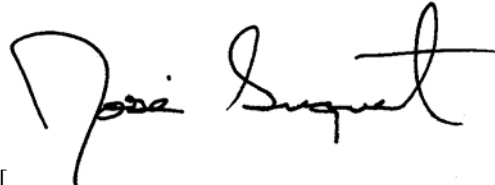
If the Subscriber is insured for family coverage and dies [or suffers dismemberment] as a result of a covered accident while insured under the Policy, The Company will pay an additional Counseling benefit.

The Insured Person is eligible to receive this benefit if:

1. The Insured person receives such therapy within [24 months] from the date of the covered accident causing the death(s) [or dismemberment]; and
2. Therapy is provided by a licensed or certified counselor; and
3. The Insured Person is covered under the Policy on the date of the covered accident causing the death [or dismemberment].

The amount payable will be [the usual and customary charges incurred by an Insured Person for such therapy, up to a maximum of [\$2,000]]. Payment of benefits will be made directly to the Subscriber; to the Subscriber's beneficiary; or to an authorized representative for counseling of a Dependent.]

PAN-AMERICAN LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Jose Siquet". The signature is fluid and cursive, with the first name "Jose" and last name "Siquet" clearly distinguishable.

[President and Chief Executive Officer]

PAN-AMERICAN LIFE INSURANCE COMPANY
[601 POYDRAS
NEW ORLEANS, LOUISIANA 70130]

AMENDATORY RIDER

This amendatory rider becomes a part of and is effective on the same date as the Policy and/or Certificate to which it is attached.

DISCLOSURE STATEMENT

1. Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Prior to applying for accelerated death benefits, the Subscriber should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents.
2. Receipt of accelerated death benefits may be taxable. Prior to applying for such benefits, the Subscriber should seek assistance from a qualified tax advisor.

ACCELERATED BENEFIT

The Accelerated Death benefit is an advance payment of part of the life insurance we will make to a Subscriber who is terminally ill. The Accelerated Death benefit is paid once in a lump sum during the Subscriber's lifetime and permanently reduces the death benefit payable for life insurance. The Subscriber must [have satisfied the Actively At Work requirements under the Policy and] have been insured under the Policy for at least [one (1) year] for a minimum benefit of [\$5,000] to qualify for this benefit.

The Subscriber must submit written proof to The Company of diagnosis and prognosis by a Physician as having an illness or physical condition which can reasonably be expected to result in death in [12 months] or less after the date of certification despite appropriate medical treatment. The Company reserves the right to decide whether such proof is satisfactory. The Company, at its own expense, may have the Subscriber examined by one or more Physicians of its choice.

Should there be a difference of opinion between these Physicians, a third opinion will be obtained from a mutually acceptable Physician. The opinion of this Physician will be binding on both parties.

The cost of the additional opinion(s) will be determined as follows:

1. If the decision is in favor of the Subscriber, We will pay for the additional Physician opinion.
2. If the decision is in favor of Us, the Subscriber will pay for the additional Physician opinion(s).

BENEFIT

The Subscriber may elect to withdraw an amount in any [\$1,000] increment subject to a minimum of [\$5,000 or 10%, whichever is greater] and a maximum of [\$100,000 or 50%, whichever is less].

The Company will determine the Accelerated Death benefit by taking the lesser of:

- a. the Subscriber's life insurance benefit in force on the day before the Accelerated Death benefit is paid; or
- b. the life insurance benefit which would be in force [12 months] after that date if the coverage is scheduled to reduce due to age within [12 months] after the benefit is paid.

If the Subscriber should die after applying for the Accelerated Benefit, but before The Company has made payment, request for the Accelerated Death benefit is void.

EFFECT ON DEATH BENEFIT

The total amount of life insurance the Beneficiary would otherwise receive is reduced by the amount of the Accelerated Death benefit paid to the Subscriber and shall not affect any accidental death benefit provisions. Payment will be made in accordance with the Beneficiary and Faculty of Payment provisions.

Upon the possible remission or cure of the terminal illness, medical condition or chronic illness of the Subscriber, no attempt will be made by The Company to recover the Accelerated Death Benefit paid.

LIMITATIONS

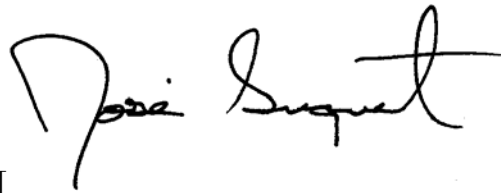
No Accelerated Death Benefit will be paid:

1. [If the Subscriber is terminally ill due to any intentionally self-inflicted injuries;]
2. [If any required group life premium is due and unpaid;]
3. [On any Dependent life insurance under the Policy;]
4. [On any conversion policy purchased in accordance with the Conversion Privilege;]
5. [To any supplemental group life insurance benefits;]
6. [Without the written consent of the assignee or Beneficiary, if the Subscriber has assigned the life insurance benefits or has named an irrevocable Beneficiary;]
7. [If any part of the life insurance must be paid to the Subscriber's child, spouse or former spouse, pursuant to a legal separation agreement, divorce decree, child support order or other court order;]
8. [If the Subscriber is terminally ill due to alcohol or drug abuse;]
9. [If a government agency requires the Subscriber to use the Accelerated Death benefit to apply for, receive or continue a government benefit or entitlement;]
10. [If the Subscriber has previously received an Accelerated Death benefit under the Policy;]
11. [Without written approval of the bankruptcy court, if the Subscriber has filed for bankruptcy;]
12. [If the Subscriber resides outside the U.S.;]
13. [If the Subscriber is retired and was not terminally ill on the date of retirement.]

WAIVER OF PREMIUM

If the Accelerated Benefit is paid, subsequent premiums for the Subscriber's life insurance under this group Policy will be waived and the Waiver of Premium Provisions will apply. Should the Subscriber recover and is no longer deemed as Terminally Ill, premium payments must resume unless the Subscriber qualifies under a Waiver of Premium benefit of this Group Policy.

PAN-AMERICAN LIFE INSURANCE COMPANY



[President and Chief Executive Officer]

EMPLOYER APPLICATION FOR GROUP [TERMLIFE AND AD&D] INSURANCE

The Employer hereby requests to insure eligible persons under Policy PAL-LP-2007, based upon its statements and representations that follow. The Employer must select the coverage and pay the required premium. Those eligible will be covered as described in this application.

Employer Name: _____ Employer Tax ID Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number: (____) _____ Direct Communications To: _____
(Name and Title)

Fax number: (____) _____ Contact e-mail address: _____

Description of Business: _____
☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other

Subsidiaries and Affiliates Included: ☐ Yes ☐ No Affiliate Name(s): _____

Subject to ERISA: ☐ Yes ☐ No If yes, ERISA plan number: _____

PROVISION AND BENEFIT SELECTION

Effective Date Requested: _____ (not sooner than the first day of the first month following acceptance by the Company).

Coverage Selected (choose all that apply):

[☐ Basic Life ☐ Supplement Life ☐ Basic AD[&D] ☐ Supplemental AD[&D]
[Optional Benefits: ☐ Waiver of Premium ☐ Accelerated Death Benefit ☐ Common Carrier ☐ Seatbelt ☐ Seatbelt with Airbag
☐ Special Education ☐ Spouse Retraining ☐ Felonious Assault ☐ Spouse Critical Period ☐ Exposure ☐ Disappearance ☐ Family Therapy]

Class of Employees:

[☐ Regular full-time Employees working [30] or more hours per week.
☐ All regular full-time Employees
☐ All Employees, except _____
Employees must be actively at work on Effective Date of coverage, if not, coverage will be effective on the first day of the month following return to active employment.]
☐ Associated Companies of the Policyholder. Effective Date: _____]

[Service Waiting Period:

[Employees hired before _____ are eligible for coverage on the Policy effective date].

[Employees hired on or after _____ will be eligible for coverage on the premium due date following [ninety (90) days] of continuous active employment].]

[Premiums:

	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Employee				
Employee + One				
Employee + Children				
Family				

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application BEFORE action is taken on this Application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this Application is declined, the Company will return the premium deposit submitted with the Application. If my coverage is approved, premium is payable monthly in advance.

I represent that, to the best of my knowledge, the information I have provided in this Application, is accurate and truthful. I understand that the Company will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences as permitted by law.

BEFORE YOU SIGN, PLEASE SEE THE BACK OF THIS DOCUMENT FOR IMPORTANT FRAUD NOTICES

Employer's Signature: _____ Date: _____

Name: _____ Title: _____

[Agent's Signature: _____ Date: _____]

Name: _____ State License #: _____

Underwritten by: PAN-AMERICAN LIFE INSURANCE COMPANY, NEW ORLEANS, LA

IMPORTANT FRAUD NOTICES [Please review the notice that applies in your state]

[FRAUD STATEMENT: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.]

[FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND, OREGON AND TEXAS: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF IDAHO AND TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KANSAS: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of fraud as determined by a court of law.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF WASHINGTON: Any person who knowingly presents false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.]

ASSOCIATION APPLICATION FOR GROUP [TERMLIFE AND AD&D] INSURANCE

The Association hereby requests to insure eligible persons under Policy PAL-LP-2007, based upon its statements and representations that follow. The Association must select the coverage and pay the required premium. Those eligible will be covered as described in this application.

Association Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number: (____) _____ Direct Communications To: _____
(Name and Title)

Fax number: (____) _____ Contact e-mail address: _____

[Association Type: _____ Number of Years in Existence: _____ Association Identification Number: _____]

Nature of Organization: _____

Was the Association organized for reasons other than for providing insurance?: ☐ Yes ☐ No

Please provide a copy of the Association's Constitution and/or By-Laws.]

PROVISION AND BENEFIT SELECTION

Effective Date Requested: _____ (not sooner than the first day of the first month following acceptance by the Company).

Coverage Selected (choose all that apply):

[☐ Basic Life ☐ Supplement Life ☐ Basic AD[&D] ☐ Supplemental AD[&D]
[Optional Benefits: ☐ Waiver of Premium ☐ Accelerated Death Benefit ☐ Common Carrier ☐ Seatbelt ☐ Seatbelt with Airbag
☐ Special Education ☐ Spouse Retraining ☐ Felonious Assault ☐ Spouse Critical Period ☐ Exposure ☐ Disappearance ☐ Family Therapy]

Class of Eligible Persons:

[All eligible Subscribers of the Policyholder.]

[Premiums:

	Rates	Number of Enrolled Members	Association Contribution %	Member Contribution %
Member				
Member + One				
Member + Children				
Family				

]

The Association understands and agrees that the [first month's estimated premium] and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application BEFORE action is taken on this Application. Coverage is not in effect unless and until the Association receives notification of acceptance from the Company. If this Application is declined, the Company will return the premium deposit submitted with the Application. If coverage is approved, premium is payable [monthly in advance].

The Association represents that, to the best of its knowledge, the information provided in this Application, is accurate and truthful. The Association understands that the Company will rely on the information provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences as permitted by law.

BEFORE YOU SIGN, PLEASE SEE THE BACK OF THIS DOCUMENT FOR IMPORTANT FRAUD NOTICES

Association's Signature: _____ Date: _____
Name: _____ Title: _____

[Agent's Signature: _____ Date: _____]
Name: _____ State License #: _____

Underwritten by: PAN-AMERICAN LIFE INSURANCE COMPANY, NEW ORLEANS, LA

IMPORTANT FRAUD NOTICES [Please review the notice that applies in your state]

[FRAUD STATEMENT: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.]

[FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND, OREGON AND TEXAS: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF IDAHO AND TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KANSAS: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of fraud as determined by a court of law.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF WASHINGTON: Any person who knowingly presents false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.]

Pan-American Life Insurance Company - Supplemental Insurance Enrollment Form

PART A

EMPLOYEE INFORMATION

Company Use Only:

Effective Date: _____

Employee's Name: Last _____ First _____ Middle Initial _____

Social Security Number

/ /

Gender: Male ☐ Female ☐ **Marital Status:** Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐

Date of Birth (Month-Day-Year)

/ /

Employee's Address: Address _____
City _____ State _____ Zip Code _____

ENROLLMENT INFORMATION

Select Coverage Type:

- ☐ Employee Only ☐ No Coverage
☐ Employee and Spouse ☐ Initial Application
☐ Employee and Dependent Child(ren) ☐ Increase in Coverage
☐ Family] ☐ Monthly Premium

Coverage Amount Selected

[Life AD&D
 Member: \$ _____ \$ _____
 Spouse: \$ _____ \$ _____
 Child: \$ _____ \$ _____]

BENEFICIARY FOR EMPLOYEE COVERAGE/RELATIONSHIP:

Primary: _____
 Name Relationship SS# Mailing Address

Contingent: _____
 Name Relationship SS# Mailing Address

(Employee is beneficiary for Dependent coverage)

DEPENDENT INFORMATION

Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender	Date of Birth Month/Day/Year	Social Security Number
Spouse		M F	/ /	/ /
Dependent Child		M F	/ /	/ /
Dependent Child		M F	/ /	/ /
Dependent Child		M F	/ /	/ /

WAIVE COVERAGE

If you are declining coverage, please check the appropriate box, sign below and return this form to your employer. Do not Complete Part B.

☐ Supplemental Life ☐ Supplemental Accidental Death and Dismemberment]

I acknowledge that I have been offered Supplemental [Life and/or Accidental Death and Dismemberment] Insurance issued by my employer. I hereby wish to waive my rights to be insured under this plan for the coverage(s) checked above. [I am aware that I must furnish evidence of insurability, satisfactory to Pan-American Life Insurance Company at my own expense if I should apply for Supplemental Life Insurance at a later date.]

Employee Signature: _____

Date: _____

EMPLOYEE SIGNATURE

☐ I hereby apply for Supplemental Life Insurance under the Provisions of the Group Policy for which I am eligible and authorize deductions from my wages to cover the cost of the insurance. Please complete Part B.]

☐ I hereby apply for Supplemental Accidental Death and Dismemberment Insurance under the Provisions of the Group Policy for which I am eligible and authorize deductions from my wages to cover the cost of the insurance. You do not need to complete Part B.]

Employee Signature: _____

Date: _____

PART B

This section to be completed only if requesting amounts over the Guarantee Issue Amounts, requesting an increased or if you are a late enrollee. If you are declining coverage, do not complete this section.

Employee's Doctor: _____ Spouse's Doctor: _____
 Address: _____ Address: _____

Employee: Height: _____ Weight: _____ Have you gained or lost more than 20 pounds in the last year?
 If yes, pounds gained: _____ lost: _____ Explain below.

Spouse: Height: _____ Weight: _____ Have you gained or lost more than 20 pounds in the last year?
 If yes, pounds gained: _____ lost: _____ Explain below.

Check yes or no for each of these questions and give details for any "yes" answers. Attach a separate sheet if more room is required.

Employee Spouse

1. During the last five years, have you been absent from work more than five consecutive working days because of an illness or injury?..... ☐Yes ☐No ☐Yes ☐No
2. Are you now under regular medical observation or taking medical treatment?..... ☐Yes ☐No ☐Yes ☐No
3. Within the last five years, have you consulted a physician for any disease or injury, or have you had or been advised to have any surgical operation or diagnostic tests?..... ☐Yes ☐No ☐Yes ☐No
4. To the best of your knowledge, have you had or been told you had an Immune Deficiency Disorder (AIDS) or the AIDS Related Complex (ARC), or test results indicating exposure to the AIDS virus?..... ☐Yes ☐No ☐Yes ☐No
5. Please check either "yes" or "no" if you have ever had or been told that you had any of the following:

	Member	Spouse		Member	Spouse
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes, Albumin or Sugar in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Disorder of Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paralysis or Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer or Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disorder of the stomach, liver or Intestines	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant Name	Condition	Date	Remaining Effects	Physician's Name & Address

I have read the statements on this application and agree that the above answers are complete and true to the best of my knowledge and belief. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health[, or any dependents named above,] to give the Company or its reinsurers any such information. A photographic copy of this authorization shall be valid as the original and that it shall be valid for 30 months (24 months in KS, KY, NM, OK) from the date signed. I understand this authorization remains in effect until revoked by me in writing. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose the protected health information have acted in reliance upon this authorization. **I CERTIFY THAT I HAVE READ THE APPLICABLE FRAUD NOTICE.**

Employee Signature: _____

Date: _____

IMPORTANT FRAUD NOTICES [Please review the notice that applies in your state]

[FRAUD STATEMENT: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.]

[FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND, OREGON AND TEXAS: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF IDAHO AND TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KANSAS: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of fraud as determined by a court of law.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF WASHINGTON: Any person who knowingly presents false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.]

Pan-American Life Insurance Company – Supplemental Enrollment Form

PART A

MEMBER INFORMATION

Company Use Only:

Effective Date: _____

Member's Name: Last First Middle Initial

Social Security Number

/ /

Gender: Male Female **Marital Status:** Single Married Widowed Divorced Legally Separated

Date of Birth (Month-Day-Year)

/ /

Member's Address:

Address

City

State

Zip Code

ENROLLMENT INFORMATION

Select Coverage Type:

- ☐ Member Only ☐ No Coverage
☐ Member and Spouse ☐ Initial Application
☐ Member and Dependent Child(ren) ☐ Increase in Coverage
☐ Family] ☐ Monthly Premium

Coverage Amount Selected

[Life AD&D
 Member: \$ \$
 Spouse: \$ \$
 Child: \$ \$

BENEFICIARY FOR MEMBER COVERAGE/RELATIONSHIP:

Primary: Name Relationship SS# Mailing Address

Contingent: Name Relationship SS# Mailing Address

(Member is beneficiary for Dependent coverage)

DEPENDENT INFORMATION

Relationship To Member	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Member's)	Gender		Date of Birth Month/Day/Year	Social Security Number
Spouse		M	F	/ /	/ /
Dependent Child		M	F	/ /	/ /
Dependent Child		M	F	/ /	/ /
Dependent Child		M	F	/ /	/ /

WAIVE COVERAGE

If you are declining coverage, check the appropriate box, sign below and return this form to the Policyholder. Do not Complete Part B.
☐ Supplemental Life ☐ Supplemental Accidental Death [and Dismemberment]]
 I acknowledge that I have been offered Supplemental [Life and/or Accidental Death and Dismemberment] Insurance issued by the Policyholder. I hereby wish to waive my rights to be insured under this plan for the coverage(s) checked above. [I am aware that I must furnish evidence of insurability, satisfactory to Pan-American Life Insurance Company at my own expense if I should apply for Supplemental Life Insurance at a later date.]

Member Signature:

Date:

MEMBER SIGNATURE

- ☐ I hereby apply for Supplemental Life Insurance under the Provisions of the Group Policy for which I am eligible and agree to pay the required premiums to cover the cost of the insurance. Please complete Part B.]
☐ I hereby apply for Supplemental Accidental Death and Dismemberment Insurance under the Provisions of the Group Policy for which I am eligible and agree to pay the required premiums to cover the cost of the insurance. You do not need to complete Part B.]

Member Signature:

Date:

PART B

This section to be completed only if requesting amounts over the Guarantee Issue Amounts, requesting an increased or if you are a late enrollee. If you are declining coverage, do not complete this section.

Member's Doctor: _____ **Spouse's Doctor:** _____
Address: _____ **Address:** _____

Member: Height: _____ Weight: _____ Have you gained or lost more than 20 pounds in the last year?
 If yes, pounds gained: _____ lost: _____ Explain below.

Spouse: Height: _____ Weight: _____ Have you gained or lost more than 20 pounds in the last year?
 If yes, pounds gained: _____ lost: _____ Explain below.

Check yes or no for each of these questions and give details for any "yes" answers. Attach a separate sheet if more room is required.

- | | Member | Spouse |
|---|--|--|
| 1. During the last five years, have you been absent from work more than five consecutive working days because of an illness or injury?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Are you now under regular medical observation or taking medical treatment?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Within the last five years, have you consulted a physician for any disease or injury, or have you had or been advised to have any surgical operation or diagnostic tests?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. To the best of your knowledge, have you had or been told you had an Immune Deficiency Disorder (AIDS) or the AIDS related Complex (ARC), or test results indicating exposure to the AIDS virus?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Please check either "yes" or "no" if you have ever had or been told that you had any of the following. | | |

	Member	Spouse		Member	Spouse
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes, Albumin or Sugar in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Disorder of Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paralysis or Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer or Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disorder of the stomach, liver or Intestines	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant Name	Condition	Date	Remaining Effects	Physician's Name & Address
----------------	-----------	------	-------------------	----------------------------

I have read the statements on this application and agree that the above answers are complete and true to the best of my knowledge and belief. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health[, or any dependents named above,] to give the Company or its reinsurers any such information. A photographic copy of this authorization shall be valid as the original and that it shall be valid for 30 months (24 months in KS, KY, NM, OK) from the date signed. I understand this authorization remains in effect until revoked by me in writing. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose the protected health information have acted in reliance upon this authorization. **I CERTIFY THAT I HAVE READ THE APPLICABLE FRAUD NOTICE.**

Member Signature: _____

Date: _____

IMPORTANT FRAUD NOTICES [Please review the notice that applies in your state]

[FRAUD STATEMENT: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.]

[FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND, OREGON AND TEXAS: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF IDAHO AND TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KANSAS: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of fraud as determined by a court of law.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF WASHINGTON: Any person who knowingly presents false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.]

<i>SERFF Tracking Number:</i>	<i>INCS-125397225</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan-American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>37914</i>
<i>Company Tracking Number:</i>	<i>PALIC PAL-LP-2007</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Group Term Life AD&D</i>		
<i>Project Name/Number:</i>	<i>PALIC Group Life/</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	INCS-125397225	State:	Arkansas
Filing Company:	Pan-American Life Insurance Company	State Tracking Number:	37914
Company Tracking Number:	PALIC PAL-LP-2007		
TOI:	L04G Group Life - Term	Sub-TOI:	L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name:	Group Term Life AD&D		
Project Name/Number:	PALIC Group Life/		

Supporting Document Schedules

	Review Status:	
Satisfied -Name:	Certification/Notice	12/21/2007
Comments:		
Attachment:		
Generic Readability.pdf		

	Review Status:	
Satisfied -Name:	Application	12/21/2007
Comments:		
See applications filed under the Form Schedule Tab		

	Review Status:	
Satisfied -Name:	Letter of Authorization	12/29/2007
Comments:		
Attachment:		
Authorization Letter.pdf		

	Review Status:	
Satisfied -Name:	Readability Certification	01/09/2008
Comments:		
Attachment:		
Generic Readability.pdf		

	Review Status:	
Satisfied -Name:	Accelerated Death Benefit Actuarial Memo	01/16/2008
Comments:		
Attachment:		
Pan Am Accelerated Death Bene.pdf		

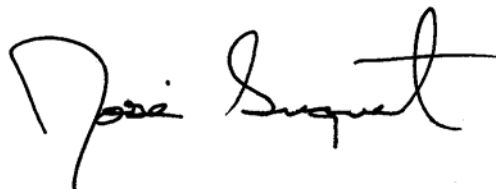
Review Status:

<i>SERFF Tracking Number:</i>	<i>INCS-125397225</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan-American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>37914</i>
<i>Company Tracking Number:</i>	<i>PALIC PAL-LP-2007</i>		
<i>TOI:</i>	<i>L04G Group Life - Term</i>	<i>Sub-TOI:</i>	<i>L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Group Term Life AD&D</i>		
<i>Project Name/Number:</i>	<i>PALIC Group Life/</i>		
Satisfied -Name:	Forms List		01/16/2008
Comments:			
Attachment:			
AR Forms listing.pdf			

**CERTIFICATION OF COMPLIANCE
FOR READABILITY**

<u>Form Number(s)</u>	<u>Flesch Readability Score</u>
PAL-LP-2007	53.2
PAL-LC-2007	53.2
PAL-LADR-2007 (Combined with Certificate)	53.2
PAL-LADBR-2007 (Combined with Certificate)	53.2

I hereby certify on behalf of Pan-American Insurance Company that the Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores.



President and Chief Executive Officer

Dated: December 21, 2007



Daniel E. LaGrone

Vice President
Associate General Counsel

601 Poydras Street – Suite 2600
New Orleans, LA 70130
Telephone 504.566.3781
Facsimile 504.566.3787
dlagrone@panamericanlife.com

Authorization Letter

December 3, 2007

COMPANY: Pan-American Life Insurance Company
NAIC Number: 67539
FEIN Number: 720281240

Insurance Commissioner:

Please accept this letter as authorization for Innovative Compliance Solutions to act as our agent for submission of policy forms and rate information and to perform each and every act necessary in connection with such submission on behalf of Pan-American Life Insurance Company.

BY:

TITLE:

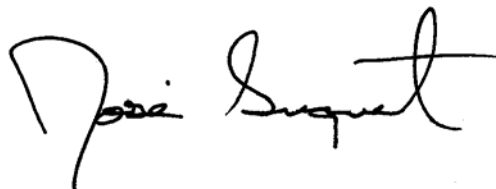
Vice President - Associate Gen Counsel

Pan-American Life Insurance Company

**CERTIFICATION OF COMPLIANCE
FOR READABILITY**

<u>Form Number(s)</u>	<u>Flesch Readability Score</u>
PAL-LP-2007	53.2
PAL-LC-2007	53.2
PAL-LADR-2007 (Combined with Certificate)	53.2
PAL-LADBR-2007 (Combined with Certificate)	53.2

I hereby certify on behalf of Pan-American Insurance Company that the Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores.



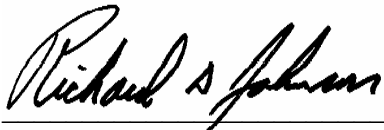
President and Chief Executive Officer

Dated: December 21, 2007

Pan-American Life Insurance Company (PAL)
Accelerated Death Benefits Amendatory Rider
Rider Form Number PAL-LADBR-2007
Actuarial Memorandum

- Item 1 **Scope and Purpose of Filing:** The purpose of this filing is to demonstrate compliance with minimum requirements of your state and show that benefits are reasonable in relationship to premiums charged. This is a new rate filing for the Accelerated Death Benefits Amendatory Rider which will only be attached to the Group Term Life Policy Form Number PAL-LP-2007. This filing may not be appropriate for other purposes.
- Item 2 **Description of Benefits:** The benefits will be payable under this group rider form in the event of the covered person's submission of proof of a terminal illness to PAL. PAL has unilateral authority in determining the adequacy and sufficiency of such proof. Benefits paid under this rider will be subtracted from the benefits otherwise payable under the policy/certificate to which it is attached. Benefits paid under this rider will not be discounted to reflect the present value of the benefits which would have otherwise be payable at the date of death. PAL will not charge any interest on the pre-paid death benefits which would have otherwise been payable at the date of death.
- Item 3 **Renewability:** The rider terminates concurrently with the policy/certificate to which it is attached.
- Item 4 **Conversion:** Not applicable.
- Item 5 **Applicability:** PAL anticipates new issues and renewals under the rider form.
- Item 6 **Morbidity:** Not Applicable
- Item 7 **Mortality:** PAL has made a minor adjustment to its mortality assumption in the group term life policy to which this rider is attached in order to account for the additional costs of this benefit.
- Item 8 **Persistency:** Not applicable
- Item 9 **Expenses:** Not applicable.
- Item 10 **Underwriting:** This rider will be automatically attached to the group term life policy without any evidence of insurability.
- Item 11 **Premium Classes:** There is no additional premium for this benefit.

- Item 12 **Claim Liability and Reserves:** Upon notice of a terminal illness, reserves will be booked based on the estimated present value of the reported but unpaid death benefits.
- Item 12 **Active Life Reserves:** Not Applicable.
- Item 13 **Trend Assumptions:** Not Applicable.
- Item 14 **Minimum Required Loss Ratio for the Form:** Not applicable. No additional premium will be charged.
- Item 15 **Anticipated Loss Ratio:** Not applicable. No additional premium will be charged.
- Item 16 **Experience on the Form:** Not applicable. No additional premium will be charged.
- Item 17 **History of Rate Adjustments:** Not Applicable.
- Item 18 **Actuarial Certification:** I certify that to the best of my knowledge and judgment, the entire rate filing is in compliance with the applicable laws of this state and with the rules of the Department of Insurance. I further certify that the benefits are reasonable in relation to the premiums.



Richard D. Johnson, FSA, MAAA
Consulting Actuary
156 Windsor Lane
New Brighton, MN 55112
(651)636-0987

1-16-08
Date

PAN-AMERICAN LIFE INSURANCE COMPANY

GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT GROUP POLICY AND CERTIFICATE FORMS LISTING

<u>Form Number(s)</u>	<u>Description</u>
<u>Group Policy</u>	
PAL-LP-2007-AR	Group Policy face page
PAL-LP-2007-TOC	Table of Contents
PAL-LP-2007-SCH	Schedule
PAL-LP-2007-DEF	Definitions
PAL-LP-2007-ELG	Eligibility Provisions
PAL-LP-2007-DEP	Dependent Provisions
PAL-LP-2007-LBEN	Life Insurance Benefits
PAL-LP-2007-CONV-AR	Conversion Privilege
PAL-LP-2007-WAV	Waiver of Premium
PAL-LP-2007-PORT	Portability
PAL-LP-2007-ACC	Accidental Death and Dismemberment
PAL-LP-2007-CLM	Claim Provision
PAL-LP-2007-BFP	Beneficiary and Facility of Payment
PAL-LP-2007-PREM	Premium Provisions
PAL-LP-2007-GEN	General Provisions
<u>Certificate</u>	
PAL-LC-2007-AR	Certificate face page
PAL-LC-2007-TOC	Table of Contents
PAL-LC-2007-SCH	Schedule
PAL-LC-2007-DEF	Definitions
PAL-LC-2007-ELG	Eligibility Provisions
PAL-LC-2007-DEP	Dependent Provisions
PAL-LC-2007-LBEN	Life Insurance Benefits
PAL-LC-2007-CONV-AR	Conversion Privilege
PAL-LC-2007-WAV	Waiver of Premium
PAL-LC-2007-PORT	Portability
PAL-LC-2007-ACC	Accidental Death and Dismemberment
PAL-LC-2007-CLM	Claim Provision
PAL-LC-2007-BFP	Beneficiary and Facility of Payment
PAL-LC-2007-PREM	Premium Provisions
PAL-LC-2007-GEN	General Provisions
PAL-LC-2007-CSCH	Certificate Schedule